

CLAIMING DIGNITY

USING LAW TO ADVANCE REPRODUCTIVE AND SEXUAL
HEALTH RIGHTS



3rd EDITION
2019

HRLN
HUMAN RIGHTS LAW NETWORK

CLAIMING DIGNITY

USING LAW TO ADVANCE REPRODUCTIVE AND
SEXUAL HEALTH RIGHTS

3RD EDITION

2019



HUMAN RIGHTS LAW NETWORK: OUR VISION

- To protect fundamental human rights, increase access to basic resources for marginalised communities, and eliminate discrimination.
- To create a justice delivery system that is accessible, accountable, transparent, efficient and affordable, and works for the underprivileged.
- To raise the level of *pro bono* legal expertise for the poor to make the work uniformly competent as well as compassionate.
- To equip through professional training a new generation of public interest lawyers and paralegals who are comfortable both in the world of law as well as in social movements, and who learn from the social movements to refine legal concepts and strategies.
- To work towards an increased awareness of rights as universal and indivisible, and their realisation an immediate goal.

‘CLAIMING DIGNITY: Using Law To Advance Reproductive And Sexual Health Rights’

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1 CHAPTER Introduction

Today in India, 160 women die of preventable causes related to pregnancy and childbirth every day - which translates to about six deaths every single hour. India accounts for 20 percent of such deaths globally.¹

The history of medicine and reproductive health in India is one in which women were merely mute beneficiaries rather than the active agents that they should have been. It is cluttered by scandals involving mass hysterectomies, illegal and unethical sterilizations, and cases of maternal mortality due to preventable pregnancy related causes. India has borne witness to a slow and gradual change in reproductive health policies through influence of social reform, cultural nationalism and changing gender relations.² Nevertheless, progress is constantly hampered by economic and cultural backwardness and issues of caste and class.

Even today, women are routinely denied their fundamental right to a life of personal liberty, privacy, health and dignity. They are frequently denied active control over their reproductive choices. Women of poor and marginalized communities, residing in rural areas, have limited access to information regarding contraceptive options available, their right to a legal and safe abortion and their right to a reasonable quality of care at government institutions. India has witnessed multiple cases of women being denied basic emergency obstetric care and being evicted from hospitals while in labour. Traditional beliefs regarding Dalits, HIV positive persons, and social stigma surrounding topics of sexual activity continues to hinder the quality of care that is accessible to women throughout the country.

1. UNICEF India. "Maternal Health in Focus." Accessed January 22, 2018. <http://unicef.in/Whatwedo/1/Maternal-Health>.

2. Hodges, Sarah. *Reproductive health in India: history, politics, controversies*. Hyderabad: Orient Longman, 2006.

Additionally, despite multiple steps taken to combat the persistent problem of child marriages, they remain rampant across the nation. Local officials and police are known to accept bribes of upto INR 500 to overlook child marriage ceremonies.

Government schemes have made progress in better informing women of their rights and attempting to change practices through provision of incentives. However, their implementation remains uneven with women from backward areas continuing to face immense obstacles in accessing proper healthcare.

Since HRLN published the second edition of Claiming Dignity in 2012, lawyers throughout the country have filed petitions and taken up issues in the key areas of concern within the scope of reproductive rights. Through conscientious efforts of both advocates and activists, the Indian courts have declared increasingly progressive judgments which impacted real change in government policies and their implementation. It ensured that marginalized persons received the healthcare they were entitled to and that their rights to a dignified life, health, privacy and to be free from torture and inhuman treatment were protected.

The following section of this book will discuss the idea of reproductive rights and all that they encompass. It will outline the major issues that India continues to face today in terms of reproductive health. These areas can be identified as: quality of care, implementation of government schemes, child marriages, unmet need for contraception, rights of the ground level health workers, access to abortion services and access to adequate nutrition. Furthermore, the book will provide an overview of the crucial domestic constitutional provisions, laws, schemes as well as international covenants and treaties that India is a signatory to and is thus legally obligated to observe.

This book aims to provide an overview of some of the most forward looking and revolutionary judgements. The book is intended to be tool for advocates and activists in their fight for reproductive health rights. HRLN has included several articles that contribute to the holistic understanding of Sexual and Reproductive Health Rights in India, written by Health Rights Activists and Workers, Academicians and Medical Practitioners. HRLN hopes that the book serves as a useful resource in drafting petitions, developing human rights trainings and most importantly, in inspiring meaningful activists to drive legal change, consequently expanding the scope of reproductive rights.

SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

Sexual and reproductive health rights are fundamentally human rights. They are universal, indivisible and undeniable. These rights stem from essential human rights like the right

to health, the right to privacy, the right to be free from discrimination, the right to not be subjected to torture or ill and degrading treatment, the right to determine the number and spacing of one's children as well as the right to be free from sexual violence.³

This book adopts an understanding of reproductive rights based on its definition provided by the 1994 International Conference on Population and Development (ICPD), which took place in Cairo, Egypt⁴. The definition offers the most comprehensive and explicit view of sexual and reproductive rights. The key aspects of the definition are as follows:



Woman lying on a bed without covers, unattended after delivery in Sonitpur, Assam

1. Access to **sexual health** information and counselling so as to promote mutually respectful and equitable gender relations, especially amongst adolescents. Adolescents are particularly vulnerable to issues like: inadequate knowledge about human sexuality; poor quality reproductive health counselling and services; high risk sexual behaviour; discriminatory social practices; negative attitude towards girls and women; and limited power over their sexual and reproductive lives.⁵

3. Amnesty International USA. *Sexual and Reproductive Health Rights*. Report. Accessed January 23, 2018. <https://www.amnestyusa.org/pdfs/SexualReproductiveRightsFactSheet.pdf>.

4. "Chapter VII: Reproductive Rights and Reproductive Health." In *Report of the ICPD*. Proceedings of International Conference on Population and Development, Egypt, Cairo. October 18, 1994. Accessed January 24, 2018. <http://www.un.org/popin/icpd/conference/offeng/poa.html>.

5. Ibid.

2. Access to safe, effective, affordable and acceptable methods of **family planning** so that couples may make informed and voluntary decisions regarding the number, spacing and timing of their children.⁶
3. Access to **reproductive health care** through the primary health care system. This includes: prenatal counselling and care; safe delivery services from a trained professional (physician/midwife); diagnostic services and treatment for pregnancy related complications; post-natal care; breastfeeding support and infant's health care; proper treatment for infertility; access to safe and legal abortion services as well as post abortion care; treatment of reproductive tract infection and sexually transmitted diseases.⁷
4. The definition also highlights that reproductive health care programs should be designed keeping in mind needs of women and adolescents and must involve them in all stages like leadership, planning, decision-making, implementation and evaluation of services.⁸

The definition provided by the 1994 ICPD Report is corroborated by a number of international human rights law instruments as well as global consensus documents. The International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) address various aspects of the above provided definition of reproductive health rights; and will be discussed in detail in the upcoming chapters of this book.

It should be noted that sexual and reproductive health rights form an integral part of the global Sustainable Development Goals as adopted by the United Nations in September 2015. Reproductive health is Goal Number Three of the 2030 Agenda, with the aim of reducing the global maternal mortality rate (MMR) to 70 deaths per 100,000 live births. It is currently at the forefront for United Nations Population Fund (UNFPA).⁹

MAJOR SEXUAL AND REPRODUCTIVE HEALTH RIGHTS ISSUES IN INDIA

In India, reproductive health issues disproportionately affect women and girls. Reproductive rights are closely associated with women's rights in general since they are a product of

6. Ibid.

7. Ibid.

8. Ibid.

9. "UNFPA & the Sustainable Development Goals | UNFPA." United Nations Population Fund. Accessed January 24, 2018. <http://www.unfpa.org/sdg#>.

persisting gender discrimination and inequalities.¹⁰ The society and the government continue fail women when it comes to reproductive health services, especially as there is a lack of available resources. Women often have restricted access to health services due to structural determinants of women's health (like gender, age, income, race, disability, ethnicity, class, and environmental factors) as well as the disabling nature of the existing legal and policy environment.¹¹

The following section identifies and discusses some key issues in women's reproductive health rights in India today.

Quality of Care

One of the most troublesome and tenacious issues in the discourse of sexual and reproductive health rights in India is the substandard quality of care provided at governmental institutions, which globally does not meet the required human rights standards.¹²

Although funds are allocated to health care through government policies and supplies and facilities are made available to the public, India continues to see poor outcomes in pregnancy related cases. A study by MacArthur Foundation¹³ shows that the maternal mortality rate (MMR) has significantly reduced from 556 maternal deaths per 100,000 live births in 2010 to 174 in 2017.¹⁴ The report concluded that although access to health care had undoubtedly improved, maternal mortality and morbidity continued to be grave issues of concern.¹⁵ Even today, approximately 45,000 women die of preventable pregnancy related causes every year in India.¹⁶ Hence, these results highlight the need to shift focus from accessibility of reproductive health care to the quality of health systems.

10. World Health Organization. Women and health: today's evidence tomorrow's agenda. World Health Organization, 2009.

11. Temmerman, Marleen, Rajat Khosla, Laura Laski, Zoe Mathews, and Lale Say. "Women's health priorities and interventions." *bmj* 351 (2015): h4147.

12. Germain, Adrienne. "Discussion Note for the ICPD Beyond 2014 Conference on Human Rights: meeting human rights norms for the quality of sexual and reproductive health information and services." In *ICPD Beyond 2014 Expert Meeting on Women's Health—rights, empowerment and social determinants, 30 September–2 October 2013, Mexico City: background paper 2b*. 2014.

13. O'Neil, So, Katie Naeve, and Rajani Ved. *An Examination of the Maternal Health Quality of Care Landscape in India*. No. b4ac5292bf6148798f37782c2920844e. Mathematica Policy Research, 2017.

14. World Health Organization. World Health Statistics 2017: Monitoring Health for the SDGs Sustainable Development Goals. World Health Organization, 2017.

15. O'Neil, So, Katie Naeve, and Rajani Ved. *An Examination of the Maternal Health Quality of Care Landscape in India*. No. b4ac5292bf6148798f37782c2920844e. Mathematica Policy Research, 2017.

16. UNICEF India. "Maternal Health in Focus." Accessed January 22, 2018. <http://unicef.in/Whatwedo/1/Maternal-Health>.



Rusty infant weighing machine in Iduli PHC, Arunachal Pradesh

The concept of quality of care in healthcare is a multidimensional one which is influenced by priorities of stakeholders. Attributes of quality of care include: better access to care through more efficient transportation systems, health networks and referral systems; effectiveness of care through availability of appropriate infrastructure, necessary medical equipment, safety and a well-trained and skilled medical staff to provide supreme care; equitability in provision of medical care; and privacy and confidentiality.¹⁷ The World Health Organization identifies the following components in establishing a quality of care: safe, effective, efficient, accessible, equitable and patient centered.¹⁸

In India, studies have shown that less than a third of healthcare providers adhere to the prescribed guidelines for patient care. Moreover, less than half of patient consultations actually results in correct diagnosis and consequently correct treatment for the patient.¹⁹ The situation only worsens when it comes to primary rural healthcare centers. Less than a third of these have regular supplies of basic amenities like water and electricity, much less essential supplies of blood, medicines and equipment required.²⁰ Additionally, patient

17. Bruce, Judith. "Fundamental elements of the quality of care: a simple framework." *Studies in family planning* 21, no. 2 (1990): 61-91.

18. World Health Organization. "Quality of care: a process for making strategic choices in health systems." (2006).

19. Das, Jishnu, Alaka Holla, Aakash Mohpal, and Karthik Muralidharan. "Quality and accountability in healthcare delivery: audit evidence from primary care providers in India." The World Bank Policy Research Working Paper, (2015).

20. India. Ministry of Health and Family Welfare. Statistics Division. *Rural Health Statistics: 2016-17*. By Vishnu Kant Srivastava, Janardan Yadav, Navanita Gogoi, Anil H. Ramteke, and Rakesh Sharma. 2017. Accessed January 25, 2018. [https://nrhm-mis.nic.in/Pages/RHS2017.aspx?RootFolder=%2FRURAL%20HEALTH%20STATISTICS%2F%28A%29RHS%20-%202017&FolderCTID=0x01200057278FD1EC909F429B03E86C7A7C3F31&View=%7B9029EB52-8EA2-4991-9611-FDF53C824827%7D](https://nrhm-mis.nic.in/Pages/RHS2017.aspx?RootFolder=%2FRURAL%20HEALTH%20STATISTICS%2F%28A%29RHS%20-%202017&FolderCTID=0x01200057278FD1EC909F429B03E86C7A7C3F31&View=%7B9029EB52-8EA2-4991-9611-FDF53C824827%7D;);

Muldoon, Katherine A., Lindsay P. Galway, Maya Nakajima, Steve Kanters, Robert S. Hogg, Eran Bendavid, and Edward J. Mills. "Health system determinants of infant, child and maternal mortality: a cross-sectional study of UN member countries." *Globalization and health* 7, no. 1 (2011): 42.

surveys have showed that the culture of patient-centered medicine is virtually non-existent in India. Neither healthcare providers, nor patients understand the importance of patient centered care. Surveys found patients generally satisfied with their care. However, they also bore evidence to barriers in medical care and treatment options.²¹

Furthermore, patients routinely report a lack of empathy and respect in the behaviours of health workers when they seek care from public healthcare institutions.²² Hospital workers are not trained to be culturally competent and compassionate towards patients. Many are denied care on account of belonging to a particular caste/tribe (like Dalits), being HIV/AIDS positive or simply being poor. In some cases, women have even reported that they were subjected to slapping and pinching from attending physicians and nurses upon screaming with pain during delivery.²³ The previous edition of *Claiming Dignity* (2012) provides synopsis and judgements of multiple cases where women were denied basic emergency obstetric treatment due to discrimination, and often forced to deliver babies in unhygienic conditions like the footpath or in the back of an auto rickshaw.²⁴ Cases like these only serve to deter women from seeking institutional care during pregnancy.

It should be noted that due to India's diverse diasporas, the quality of maternal health varies considerably across states and urban and rural areas. Maharashtra and Kerala are the only two states with a MMR of below 70. On the other hand, Assam suffers from an MMR of 300. Although 67 percent of India's population resides in rural areas²⁵, healthcare facilities and providers are largely established in urban settings.²⁶ Hence, issues of access and quality of care disproportionately affect women from rural areas. Disparity also occurs in the quality of care provided to others within the same region. For instance, women who live below poverty one and thus have lower income and illiteracy, and women of scheduled castes and scheduled tribes are less likely to receive or seek proper maternal healthcare

21. Narichiti, Victoria. Patient Centered Hospitals: A Study to Evaluate the Effectiveness of Health Care Delivery in Three Selected Hospitals in Guntur District, Andhra Pradesh, India. Doctoral dissertation. Acharya Nagarjuna University. 2013.

22. Ardey, Rashmi, and Rajeev Ardey. "Patient perceptions and expectations from primary health-care providers in India." *Journal of family medicine and primary care* 4, no. 1 (2015): 53.

23. Chattopadhyay, Sohini. "The horrifying sights and sounds from the labour room of an Indian public hospital." Quartz. June 11, 2015. Accessed January 25, 2018. <https://qz.com/422338/in-horrific-indian-hospitals-women-in-labour-are-slapped-when-they-scream/>.

24. Human Rights Law Network. *Claiming dignity: reproductive rights & the law*. Socio Legal Information Cent, 2012.

25. World Bank. "Rural population (% of total population)." Rural population (% of total population) | Data. 2017. Accessed January 24, 2018. <https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS>.

26. India. Ministry of Health and Family Welfare. Department of Health and Family Welfare. *State/UT Wise Number of Government Hospitals and Beds in Rural and Urban Areas (including Community Health Centres) in India as on 31st March 2016*. New Delhi: Ministry of Health and Family Welfare, 2017.

services.²⁷ The quality of care available is further hindered by rampant corruption, lack of hospital workers, shortfall of number of available health workers (like Accredited Social Health Activists), poor management of healthcare institutions and poor regulations.

Implementation of Government Schemes and Entitlements

In September 2017, the Central Government of India launched the Pradhan Mantri Matru Vandana Yojna (PMMVY) - rechristened Maternity Benefit Program - with the aim of incentivizing proper healthcare for pregnant and lactating women. It provides a total INR 6000 to women over 19 years of age for the pregnancy and live births of their first two children as well as compensation for wage loss occurred during this period.²⁸ In February 2017, in collaboration with the UNFPA, the Indian Government launched Saathiya scheme which hopes to educate over 26 crore adolescents regarding matters of gender, sexuality, consent and abortion, among other things, through 1.6 Lakhs peer educators. The scheme hopes to correct common misconceptions regarding matters of sex in the society and normalize ideas of homosexuality and practicing safe sex.²⁹

This is not the first time that the Government has launched ambitious programs to combat problems which plague sexual and reproductive rights.³⁰ However, persisting issues indicate that the governments' schemes are poorly implemented and do not fully reach the intended beneficiaries. In a country as vast as India and with an incredibly diverse geography and population, the existing government machinery and bureaucratic systems regularly fail to deliver the promised benefits and entitlements to women in need. The reasons for the inefficiency and ineffectiveness of the government may be attributed to a lack of necessary accountability, the stubborn problem of corruption, lack of proper

27. Vora, Kranti S., Dileep V. Mavalankar, Kv Ramani, Mudita Upadhyaya, Bharati Sharma, Sharad Iyengar, Vikram Gupta, and Kirti Iyengar. "Maternal Health Situation in India: A Case Study." *Journal of Health, Population and Nutrition* 27, no. 2 (2009). doi:10.3329/jhpn.v27i2.3363.

28. India. Ministry of Women and Child Development. *Pradhan Mantri Matru Vandana Yojna (PMMVY) - Scheme Implementation Guidelines*. By Ministry of Women and Child Development. September 2017. Accessed January 25, 2018. http://www.wcd.nic.in/sites/default/files/PMMVY%20Scheme%20Implementation%20Guidelines%20_0.pdf.

29. Government of India. Ministry of Health and Family Welfare. "Health Secretary launches 'SAATHIYA' Resource Kit and 'SAATHIYA SALAH' Mobile App for Adolescents." News release, February 20, 2017. Press Information Bureau . Accessed January 25, 2018. <http://pib.nic.in/newsite/PrintRelease.aspx?relid=158578>; Bureau, Outlook Web. "Health Ministry's Saathiya Scheme To Educate Adolescents On Gender, Homosexuality And Abortion." <https://www.outlookindia.com/>. February 20, 2017. Accessed January 25, 2018. <https://www.outlookindia.com/website/story/health-ministrys-saathiya-scheme-to-educate-adolescents-on-gender-homosexuality-/298026>.

30. See section titled 'Legal Protections and Schemes in India', pg. , for a complete list of both Centre and State sponsored schemes.

monitoring of implementation of schemes and an incorrect allocation of incentives. Hence, despite presence of multiple schemes for the reproductive health rights of women, India continues to see a desperate lack of access to quality care and consequently, a high MMR as compared to other nations.



Women assemble in Anganwadi in Hollambi Kalan, New Delhi for an awareness workshop on maternity benefit schemes of the government

For instance, the above described PMMVY scheme is implemented entirely through Accredited Social Health Activists (ASHAs). However, there is a dire shortage of trained ASHAs and ASHA Facilitators in many rural areas of India. Arunachal Pradesh alone reports an urgent need for over 347 ASHA workers in 2016-17 for areas where no ASHAs are currently present.³¹ Even when available, ASHAs frequently lack the necessary training to deal with issues that may arise. Furthermore, they are forced to deal with a lot of red tape when it comes to receiving their incentives, and even then, they often never see the money they are entitled to. Consequently, in many cases, ASHAs do not provide the healthcare assistance that they should and do not adequately inform people of the benefits that they can avail. Often they do not even visit vast areas of the population and hence, people living there have no access to much needed reproductive health and choices counselling.

31. India. National Health Mission. *National Health Mission: State Program Implementation Programs (2017-18)*. By Government of Arunachal Pradesh. 2017. Accessed January 25, 2018. <http://nhm.gov.in/nrhm-in-state/state-program-implementation-plans-pips/arunachal-pradesh.html>.

Child Marriages

Child marriages form one of the key underlying causes of India's reproductive health crisis. Studies have attempted to establish a direct correlation between pervasiveness of child marriages and reproductive health outcomes through empirical evidence. They concluded that child marriage plays a significant contribution in causing rapid and repeated child birth, lack of use of modern methods of contraception, unintended pregnancies, medical termination of pregnancies, and inadequate use of available maternal health services.³² Young girls' bodies are unprepared to handle the extreme stress of pregnancy which invariably leads to higher maternal mortality and severe morbidity. This could be a result of lack of education as most women marrying in their adolescent have limited access to education. Essentially, child marriage makes girls vulnerable and limits their control over fertility related choice. They are often victims of violence, exploitation and neglect.

According to the 2011 census, more than 12 million persons were married before the age of ten, of which 65 percent were girls.³³ Child marriages are a tried and tested way for families to pass on property and wealth. Furthermore, in a dominantly patriarchal society like India's, they re-enforce a social order in which males hold the dominant power. Poverty stricken families see girls as a liability with little to no economic role and prefer marrying them off early for lower dowries to get rid of an extra mouth to feed. The problem of child marriages is made all the more difficult to eradicate due to its massive scale as well as under-recognized and largely unreported nature.

According to UNICEF, child marriage has significantly decreased from 47 percent in 2006 to 27 percent in 2016.³⁴ This can be attributed to enactment of laws like the Prohibition of Child Marriage Act (2006) which was implemented with great urgency as a result of the Supreme Court order in *Forum for Fact Finding Documentation and Advocacy v. Union of India*.³⁵

Nevertheless, change has been slow coming. According to UNICEF: "Broad, multi-faceted strategies are needed to target different aspects of the problem, including deep-rooted social norms and behaviours, the perceived low value of girls, limited access to education, exposure

32. Godha, Deepali, David R. Hotchkiss, and Anastasia J. Gage. "Association Between Child Marriage and Reproductive Health Outcomes and Service Utilization: A Multi-Country Study From South Asia." *Journal of Adolescent Health* 52, no. 5 (May 2013): 552-58. Accessed January 25, 2018. doi:10.1016/j.jadohealth.2013.01.021.

33. India. Ministry of Home Affairs. Office of the Registrar General & Census Commissioner, India. *Census of India, 2011*. By Government of India. New Delhi: Office of the Registrar General & Census Commissioner, India, Ministry of Home Affairs, Govt. of India, 2011.

34. UNICEF India. "Child Marriage - Introduction." Child Marriage | UNICEF. Accessed January 25, 2018. <http://unicef.in/Whatwedo/30/Child-Marriage>.

35. Human Rights Law Network. *Claiming dignity: reproductive rights & the law*. Socio Legal Information Cent, 2012.

to violence, restricted freedom of movement and economic vulnerability.”³⁶ Even today, dowries remain a prominent part of marriage traditions in India. With higher education, a girl’s parents are forced to pay higher dowry (whether cash or kind). This essentially forms an incentive for marrying girls off at an early age with little to no education. Law enforcement intervention in child marriages remains weak as they are seen a part of culture and traditions - which the society places above laws. Police and officials are ultimately a part of society and hence unwilling to go against their communities. Therefore, instances are rarely reported with officials accepting bribes and basically undermining the existing laws.

Additionally, the Prohibition of Child Marriage Act (POCM), 2006, is limited in its outlook on child marriages. Like the previously existing and outdated legislation, ‘The Child Marriage Restraint Act 1929’, POCM does not address the crucial aspect of automatically voiding a child marriage. Rather, it specifies a marriage may only be nullified in cases where a child has been taken from his guardians through use of force, deceit, fraud, deception, enticement or trafficking. According to a report by the Office of the United Nations High Commissioner on Human Rights (OHCHR), this aspect of the law often create confusion for law enforcement officials, courts as well as the people.³⁷ However, it can be argued that since the law does not grant consent to minors, all child marriages are necessarily a result of some form of force or coercion and must thus be automatically declared void.

Child marriage has a considerable impact on almost all facets of achieving the Sustainable Development Agenda for 2030 and has thus been regarded as an issue of utmost priority by UNICEF in India.³⁸

Unmet Need for Family Planning

With a current population of 1.324 billion³⁹, India is poised to be the most populous country, surpassing even China by 2024.⁴⁰ Population control has been at the forefront

36. UNICEF India. “Child Marriage - Introduction.” Child Marriage | UNICEF. Accessed January 25, 2018. <http://unicef.in/Whatwedo/30/Child-Marriage>.

37. United Nations. Office of the United Nations High Commissioner on Human Rights. Preventing and eliminating child, early and forced marriage Report of the Office of the United Nations High Commissioner for Human Rights. April 02, 2014. Accessed January 25, 2018. www.ohchr.org/EN/HRBodies/HRC/RegularSessions/.../A-HRC-26-22_en.doc.

38. UNICEF India. “Child Marriage - Introduction.” Child Marriage | UNICEF. Accessed January 25, 2018. <http://unicef.in/Whatwedo/30/Child-Marriage>.

39. World Bank. “Population, total.” Population, total | Data. 2016. Accessed January 29, 2018. <https://data.worldbank.org/indicator/SP.POP.TOTL>.

40. Chamie, Joseph, and Barry Mirkin. “India’s Population: Becoming Number One.” India’s Population: Becoming Number One | YaleGlobal Online. August 10, 2017. Accessed January 29, 2018. <https://yaleglobal.yale.edu/content/indias-population-becoming-number-one>.

of the government's agenda since India experienced a population boom in the 1960s. The government has adopted a variety of methods as a part of its family planning initiative. In the 1950s and 60s, the program consisted of a largely clinical approach focused on establishment of family planning facilities and the 'Information-Education-Communication' (IEC) program. In the 1970s, the Family Planning Program (FPP) became incentive-based, target-oriented, time-bound, and sterilization focused.

The World Health Organization (WHO) defines the unmet need for family planning as the need of those women who are fertile and sexually active; report not wanting to have any more children or wanting to space the birth of their next child; but who are not currently using any means of contraception.⁴¹ Unmet need points to the gap between a woman's reproductive intent and contraceptive choice. This concept is vital when measuring the effectiveness of family planning programs in empowering women with reproductive choice so that they are not forced into making choices due to pressure from their spouses or in-laws, as is common in the Indian society. In fact, a study found that the main reason for unmet need for family planning was opposition by family members.⁴² Hence, it is the central, and perhaps the most accurate, indicator when monitoring the progress of family planning programs.

Despite of the robustness of the current FPP, the unmet need for family planning in India remains one of the largest in the world at 20.5 percent of the population.⁴³ The rates vary drastically over states with some reporting an unmet need for contraception at well over 20 percent. For instance, Siwan, a region of Bihar records an unmet need for family planning at an astonishing 56.4 percent. A study of married women of reproductive age in urban Tamil Nadu showed a prevalence of unmet need for family planning at a shocking 39 percent. The study in Tamil Nadu concluded that factors like "higher education, late marriage, more than the desired family size, poor knowledge of family planning, poor informed choice in family planning and poor male participation" could be associated with unmet need for family planning.⁴⁴

41. "Unmet need for family planning." World Health Organization. Accessed January 29, 2018. http://www.who.int/reproductivehealth/topics/family_planning/unmet_need_fp/en/.

42. Veena V, Holla R, Parasuramalu BG, Balaji R. "Unmet Need For Family Planning: a Challenge to Public Health". *Natl J Community Med* 2014; 5(4):401-5.

43. Muttreja, Poonam. "Unmet Needs in Family Planning - Health Files by Poonam Muttreja | ET HealthWorld." ETHealthworld.com. May 30, 2016. Accessed January 29, 2018. <https://health.economicstimes.indiatimes.com/health-files/unmet-needs-in-family-planning/1527>.

44. Bhattathiry, Malinim, and Narayanan Ethirajan. "Unmet need for family planning among married women of reproductive age group in urban Tamil Nadu." *Journal of Family and Community Medicine* 21, no. 1 (Spring 2014): 53. Spring 2014. Accessed January 29, 2018. doi:10.4103/2230-8229.128786.

Studies have also found a significant variation in the percentage of unmet need by age, education, and male involvement in decision making. The proportion of women with unmet need for contraception decreases as the level of education increases. Among illiterate women, the percentage of unmet need may be as high as 91.5 percent.⁴⁵ Hence, women with a level of education less than primary school faced greater obstacles in using contraceptives. With an increase in age, unmet need also increased. However, in these cases, unmet need was usually concerned with limiting the number of children rather than spacing or delaying the next child. Most notably, in cases where males participate in the decision making process associated with family planning, unmet need for contraception reduces dramatically.⁴⁶

The current situation concerning unmet need for contraception in India shows that a large number of women do not have bodily autonomy and freedom of reproductive choice without any external influence.

Access to Safe Abortion Services

The Debate on Abortion

Abortion is one of the most vigorously debated and argued upon issues when it comes to the discourse of reproductive rights of women. Those against abortion cite pro-life reasons arguing that life begins at conception. Hence abortion is akin to murder and directly defies the sanctity of human life. A civilized society cannot allow an individual to intentionally harm another without punishment. Hence it follows that abortion must be treated similarly. They argue that abortion only causes intense psychological pain and stress for minor and young women who often avail abortion services. They instead suggest adoption as an alternative. They argue that abortion should not be permissible even in cases of rape as it ultimately punishes the innocent unborn child. Government policies should instead focus on contraception to prevent unwanted pregnancies, or even preach abstinence.

On the other hand, pro-choice arguments assert that a foetus is attached to the mother by the placenta and umbilical cord. Hence, it cannot be regarded as a separate entity from the mother. It cannot exist outside the womb and its health is dependent on the mothers'. They contend that the concept of human life is distinct from the concept of personhood. The pro-choice argument is centre on the idea that fundamental human rights include the

45. Patil, Supriya Satish, M. P. Durgawale, and S. R. Patil. "Epidemiological correlates of unmet need for contraception in urban slum population." *Al Ameen J Med Sci* 3, no. 4 (2010): 312-316.

46. Vasudevan, Kavita, and C. Soundarya. "Assessment of unmet need for contraception in an urban area of Pondicherry." *National Journal of Research in Community Medicine* 5, no. 4 (2016): 223-8.

right of a woman to have control over her body and health. Reproductive choices are a crucial part of these fundamental rights and taking them away is nothing short of a crime against humanity.

Situation in India

Due to passionate notions against abortions, services available are frequently unavailable to the full extent of the law and unsafe even when available. Data suggests that in developing countries, over 200 million women have no access to modern contraceptives which results deaths from unsafe abortions of unwanted pregnancies. The International Conference on Population Development Beyond 2014 Global Report notes that member states have committed to addressing maternal mortality and morbidity that result from unsafe abortions.⁴⁷

In India, the problem of unsafe abortions all the more rampant with approximately 50 percent of the abortions performed being unsafe.⁴⁸ In a country of more than a billion people, existing laws do not guarantee access to safe abortion services. Although the Medical Termination of Pregnancy Act (1972) has legalized abortions in India, there continues to exist end number of barriers that prevent women from accessing safe and legal abortion services. There exists skewness in the distribution of abortion facilities in urban and rural areas. Public health centers have limited availability of abortion services due to a considerable shortage of adequately trained staff as well as required supplies and equipments. There are barriers in relation to abortion providers who frequently deny women a choice between the available medical and surgical methods and insist on the husband's consent. Moreover, women are forced to incur high costs to avail abortion services. This leads them to seek cheaper options available, which are also often unsafe and lead to post abortion complications, morbidity and mortality.⁴⁹

A study by the Guttmacher Institute based in New York showed that only 5 percent of abortions in India occur in public health facilities, which are the key providers of

47. International Conference on Population and Development Beyond 2014. ICPD Beyond 2014. ICPD 2014 High-Level Global Commitments: Implementing the Population and Development Agenda. United Nations. 29-30.

48. "New evidence from India on ways to improve safe abortion access and knowledge." Ipas. May 05, 2017. Accessed February 01, 2018. <http://www.ipas.org/en/News/2017/May/New-evidence-from-India-on-ways-to-improve-safe-abortion-access-and-knowledge.aspx>.

49. Iyengar, Kirti, Sharad D. Iyengar, and Kristina Gemzell Danielsson. "Can India transition from informal abortion provision to safe and formal services?." *The Lancet Global Health* 4, no. 6 (2016): e357-e358.

health care for poor women in rural areas.⁵⁰ Practically, getting an abortion can be a monumental task for women. For an average rural Indian women, a safe abortion requires the following: finding an individual to accompany her to an unknown city as licensed services are often not available in their vicinity; arranging for childcare in cases of women with kids; arranging for funds for transportation and for the procedure; and spending considerable time away from their families whereby their absence raises questions and reduces confidentiality.⁵¹ When licensed providers are easily available, many women prefer not to seek them. Although studies show that women overwhelmingly prefer medical abortion (that is, abortions through use of drugs) over surgical options.⁵² This may be due to well founded fears of higher complication rates from surgeries, wanting staff skills and low adherence to proper protocol. In fact, only 32 percent of public health care facilities report the ability to provide safe surgical abortion services.⁵³ However, facilities often do not provide the option of medical options, leaving women unsure of whom to consult.⁵⁴

Hence, an estimated 75 percent of abortions are carried out through use of over the counter drugs bought from chemists and informal vendors rather than in proper health care institutions.⁵⁵ Two of the most commonly used drugs are Mifepristone and Misoprostol with annual sales as high as 11 million.⁵⁶ Notably, official number indicates only 700,000 abortions yearly.⁵⁷ This gap suggests under-reporting by formal providers and provision of services by unlicensed providers. A survey of 577 chemists conducted in 2010⁵⁸ found

50. Singh, Susheela, Chander Shekhar, Rajib Acharya, Ann M. Moore, Melissa Stillman, Manas R. Pradhan, Jennifer J. Frost et al. "The incidence of abortion and unintended pregnancy in India, 2015." *The Lancet Global Health* 6, no. 1 (2018): e111-e120.

51. Iyengar, Kirti, Sharad D. Iyengar, and Kristina Gemzell Danielsson. "Can India transition from informal abortion provision to safe and formal services?." *The Lancet Global Health* 4, no. 6 (2016): e357-e358.

52. Tamang, Anand, Shareen Tuladhar, Jyotsna Tamang, Bela Ganatra, and Bishnu Dulal. "Factors associated with choice of medical or surgical abortion among women in Nepal." *International Journal of Gynecology & Obstetrics* 118 (2012): S52-S56.

53. Chaturvedi, Sarika, Sayyed Ali, Bharat Randive, Yogesh Sabde, Vishal Diwan, and Ayesha De Costa. "Availability and distribution of safe abortion services in rural areas: a facility assessment study in Madhya Pradesh, India." *Global health action* 8, no. 1 (2015): 26346.

54. Iyengar, Kirti, Sharad D. Iyengar, and Kristina Gemzell Danielsson. "Can India transition from informal abortion provision to safe and formal services?." *The Lancet Global Health* 4, no. 6 (2016): e357-e358.

55. Singh, Susheela, Chander Shekhar, Rajib Acharya, Ann M. Moore, Melissa Stillman, Manas R. Pradhan, Jennifer J. Frost et al. "The incidence of abortion and unintended pregnancy in India, 2015." *The Lancet Global Health* 6, no. 1 (2018): e111-e120.

56. Kay, Meera. "Unsafe abortion: why restricting abortive drugs only makes a bad situation worse." *BMJ: British Medical Journal (Online)* 346 (2013).

57. *ibid.*

58. Janani. "Findings on the use of medical abortion drugs through chemist/retailer, doctor and Surya health promoter (SHP): Survey conducted by the Clinical Research Team." (2010).

that 80 percent have little information regarding proper prescription of these drugs: like accurate dosage, eligibility for safe administration of the drugs and possible side-effects.⁵⁹ Taking over the counter drugs can be exceptionally dangerous because there is no assessment of gestational age and no screening of contraindications (like allergies). Moreover, women who rely on self-administered methods of abortion often do not have sufficient information regarding the drugs they take, follow-up care required and quality contraceptives which can prevent future unintended pregnancies.

Contraception and Its Role in Fostering Unlicensed and Unsafe Abortions

Unintended pregnancies account for nearly half of the total number of abortions in India.⁶⁰ This indicates that there is abysmal access to information and availability of contraceptive choices. Although there exist government initiatives to inform women of options like sterilizations, IUCDs, condoms, and the newly introduced Injectable contraceptives. Accredited Social Health Activists (ASHAs) are appointed to reach out to women in rural and oppressed areas and counsel them about the available methods through public health schemes for no cost. However, in reality, ASHAs cannot always reach out to the communities that they are meant to as their efforts are greatly hindered by a lack of resources and no incentives. The plight of social health workers will be discussed in greater depth in the next section of the book.

The lack of access to contraception is only exacerbated by the prevalent misconceptions and cultural traditions in the society. For instance, condoms have an extremely negative connotation amongst middle-class and poor of the society. Condoms are associated with protection from sexually transmitted diseases like AIDS and therefore, their use is considered synonymous with adultery and purchase of sex from prostitutes.⁶¹ Sex outside of marriage remains a taboo in India. Even basic conversations regarding sex become tightly regulated due the subsisting social and cultural environment. This is evident in the recent ban on condom advertisements from prime-time television between 6 am to 10 pm.⁶² This

59. Visaria, Leela, Alka Barua, and Ramkrishna Mistry. "Medical abortion in India: role of chemists and providers." *Economic and Political Weekly* (2008): 35-40.

60. Singh, Susheela, Chander Shekhar, Rajib Acharya, Ann M. Moore, Melissa Stillman, Manas R. Pradhan, Jennifer J. Frost et al. "The incidence of abortion and unintended pregnancy in India, 2015." *The Lancet Global Health* 6, no. 1 (2018): e111-e120.

61. Mahendru, Ritu. "India's Abortion Epidemic." *The Diplomat*. July 11, 2017. Accessed February 01, 2018. <https://thediplomat.com/2017/07/indias-abortion-epidemic/>.

62. Gettleman, Jeffrey, and Suhasini Raj. "India Bans Condom Ads From Prime-Time TV." *The New York Times*. December 12, 2017. Accessed February 01, 2018. <https://www.nytimes.com/2017/12/12/world/asia/india-condom-ad-ban.html>.

social stigma prevents single or divorced women from seeking abortion services. Lack of institutional support for such women makes them vulnerable to unsafe abortions. They become fearful of seeking private healthcare facilities as well due to anxiety of their sexual relationship outside marriage being discovered. Hence, in many cases, they end up seeking medical practitioners of unknown qualifications and questionable skills; and thus choosing ‘confidentiality over safety and quality’.⁶³

Rights of Ground Level Health Workers

Ground level health workers form the first line of contact for the provision of health care in India. The Declaration of Alma-Ata of 1978 was a milestone as it identified primary healthcare as central in achieving health for all and subsequently attaining overall social and economic development.⁶⁴ The World Health Organization defines Community Health Workers (CHWs) as members of the community - selected by the community and therefore, answerable to the community that they serve. They are supported by the public health system through which they receive professional training in accordance with the role they play and their responsibilities.⁶⁵ Essentially, they act as intermediaries between the communities and the health system, thus improving community engagement and reducing the social and cultural barriers that result in poor health.

India has introduced programs like Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs) and Anganwadi workers. The ASHA program was introduced in 2005 by the National Rural Health Mission. ASHAs are primarily literate women residents of a village who are married, widowed or divorced. They are chosen through a rigorous selection process involving community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the village Health Committees and Gram Sabha.⁶⁶

Essentially, ASHAs perform three key roles as follows:

First, ASHAs act as activists who create awareness of good health practices and mobilize the community towards increased utilization and accountability of the existing health

63. Mahendru, Ritu. “India’s Abortion Epidemic.” *The Diplomat*. July 11, 2017. Accessed February 01, 2018. <https://thediplomat.com/2017/07/indias-abortion-epidemic/>.

64. World Health Organization, and World Health Organization. “Alma Ata Declaration.” *Geneva: World Health Organization* (1978).

65. World Health Organization. “Community health workers: What do we know about them.” Geneva: WHO Department of Human Resources for Health (2007).

66. Ministry of Health & Family Welfare, Government of India. “About ASHA - Government of India.” National Rural Health Mission. Accessed February 05, 2018. <http://nhm.gov.in/communitisation/asha/about-asha.html>.

services. This includes counselling women on contraception, birth preparedness, breast-feeding and immunization.⁶⁷

Second, ASHAs facilitate health services available at Anganwadi/ Sub-centers/ Primary Health Centers and assist pregnant women in availing proper ante-natal check-ups, institutional deliveries, and post-natal checkups through government schemes like Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK) and Pradhan Mantri Matru Vandana Yojana (PMMVY), for which they receive incentives based on performance.⁶⁸

Third, ASHAs function as ‘service extension workers’, meaning that they are provided with condoms, oral contraceptive pills, delivery kits and essential life saving drugs like cotrimoxazole and chloroquine, which they are trained to use through a short yearly training program.⁶⁹

Since their conception, there have been multiple studies to evaluate the effectiveness of the program and identify the obstacles that limit its vast outreach. A study published in *AIDS Care Journal* in 2010⁷⁰ found that the capacity of ASHAs to effectively perform their roles and increase quantitative health outcomes is institutionally limited by the following:

- (a) the outcome based remuneration structure;
- (b) poor institutional support;
- (c) the rigid hierarchical structure of the health system;
- (d) lack of participation at the community level;

ASHA workers need institutional and infrastructural support in order to be effective in their prescribed roles. However, they often do not receive it, and subsequently face many obstacles in fulfilling their tasks.

Monetary Incentives

The monetary incentives that ASHAs are entitled to are a key factor of influence when it comes to the performance of ASHA workers. ASHAs receive no fixed salary and are entirely dependent on the incentives they receive under mentioned government schemes. This system inevitably leads to neglect of activities which are non-incentivized. ASHAs naturally concentrate on activities which provide them with the greatest remuneration such as female

67. *ibid.*

68. *ibid.*

69. Saprii, Lipekho, Esther Richards, Puni Kokho, and Sally Theobald. “Community health workers in rural India: analysing the opportunities and challenges Accredited Social Health Activists (ASHAs) face in realising their multiple roles.” *Human resources for health* 13, no. 1 (2015): 95.

70. Scott, Kerry, and Shobhit Shanker. “Tying their hands? Institutional obstacles to the success of the ASHA community health worker programme in rural north India.” *AIDS care* 22, no. sup2 (2010): 1606-1612.

sterilization, immunization targets, hospital deliveries etc. ASHAs are paid INR 1500 for each female sterilization thus they promote it over alternate methods of contraception such as condoms and oral contraceptives. The incentive based model ultimately skews the provision of healthcare for the sections of the population who are entirely dependent on ASHAs for advice on proper healthcare and counselling.

Inconsistent Payment of Incentives

One of the biggest obstacles that ASHAs face is a lack of consistent payments for the work that they do. Interviews with ASHAs have revealed that they receive limited, inconsistent and irregular payments. Since ASHAs have no fixed salary, their income is wholly contingent on incentives. This situation can be very frustrating for ASHA workers. Irregular payments cause financial instability for ASHAs and make it difficult for workers to make ends meet. ASHAs often find it difficult to manage basic needs of their families, such as education for their children, leading to negative repercussions with her husband and family. They often do not receive the necessary support from their husbands who disapprove of their work, especially considering that it brings in little to no money. Hence, ultimately, lack of consistent payments affects the ability of an ASHA to execute her duties and causes her to neglect her role as the first point of contact for healthcare for communities.

It should be noted that Anganwadi workers (AWWs) receive fixed payments for their work. Moreover, the incentives they receive are higher than those of ASHAs. Such differences naturally demoralize ASHA workers, particularly considering that they believe their roles and responsibilities require a much greater workload as compared to AWWs who have limited tasks.⁷¹

Irregular payments make ASHAs weary of the bureaucratic red tape. An HRLN fact finding team visited Jafrabad, in the Seelampur area of New Delhi and interviewed the ASHA worker responsible for the area, Safiya Begum Imtiyaz. She informed the team that she had been forced to work for no money for almost a year now, with the last payment she received being in April 2017. She has visited the office to ask for her payments to be processed multiple times to no avail. She has ensured that her documents are in order; her AADHAR card has been linked to her bank accounts and all necessary paperwork has been completed. Nevertheless, she is repeatedly informed by government officials that she

71. Saprii, Lipekho, Esther Richards, Puni Kokho, and Sally Theobald. "Community health workers in rural India: analysing the opportunities and challenges Accredited Social Health Activists (ASHAs) face in realising their multiple roles." *Human resources for health* 13, no. 1 (2015): 95.

must wait for some time longer for her payment to be processed. Safiya Begum added that ASHA workers can only receive the incentive they are entitled to under schemes like JSY once the women that they assist have received their payments. However, since women are rarely paid the compensation that they are entitled to, ASHA workers are often forced to wait, at times even forgo, their payments. Safiya Begum elaborated that the entire process under JSY, JSSK and PMMVY schemes could be extremely challenging. For instance, the first step to obtaining first installment of payment under JSY requires an ASHA worker to assist pregnant women in registering their pregnancy. However, when ASHAs accompany women to dispensaries or hospitals for the registration of pregnancies under this scheme, they are informed that no such scheme exists and that they have received no directive from the government to process any payments under any such act. Thereafter, they ask ASHAs to first obtain official letters from the MLA of the area to proceed with registration, which can often prove to be a hassle. Additionally, the full amount of entitlement is rarely paid to ASHA workers. Safiya Begum stated that although she had read newspaper reports of the government announcing increased incentives for ASHAs, no such increments had been made in reality.

Furthermore, the community usually failed to realize that ASHAs are as dependent on payments from government schemes as they are. In cases of delayed payment, partial payment or non-payment of incentives to women, they frequently placed the blame on ASHA workers, mistaking them for government salaried employees. They accuse ASHA workers of misappropriating the funds, which eventually damages the relationship that ASHAs have with the community and fosters mistrust, thus hindering their ability to perform their roles effectively.⁷²

Recruitment and Training

As mentioned above, the government guidelines for ASHAs suggest that they must undergo a rigorous selection process in order to be appointed as ASHAs. However, studies have shown that the process of recruitment of ASHAs is in fact riddled with favoritism and nepotism and thus highly politicized instead of being based on merit. ASHAs are appointed in the hope of getting a more permanent government role, like that of AWWs, rather than on basis of merit; ability to fulfill duties effectively; and capacity to volunteer. Such practices frequently go unreported due to fear of repercussions.⁷³

72. *ibid.*

73. *ibid.*

An unduly influenced recruitment process inevitably leads to appointment of ASHAs to a village they do not actually reside in, thus making it all the more difficult for them to fulfill their responsibilities. Non-resident ASHAs have been reported to remain absent from their work and have a lack of rapport with the villagers. Additionally, favoritism in recruitment frequently leads to appointment of ASHA workers who are less educated than the minimum level required. Such workers are inevitably unable to fulfill basic tasks under their domain like preparing reports required or filling out forms/registers. They are seen as having limited capacity and knowledge to support their co-workers.⁷⁴

Furthermore, they often do not receive adequate training to supplement their education and equip them to handle situations in the field.⁷⁵ ASHAs are typically required to undergo a 23 day training program upon induction along with trainings in the following years. An evaluation of ASHAs commissioned by the National ASHA Mentoring Group reported that 70 to 90 percent of ASHAs stated that better training was their single greatest requirement for better performance.⁷⁶ Reports have shown that in Bihar, a third of the ASHAs never received any formal training, whereas the rest underwent a seven day program and learned the rest by reading through manuals provided.⁷⁷ ASHA's performance is adversely impacted by poor training on how to counsel and advise women on their reproductive health and choices. Training is overly focused on incentives rather than the activist role that should ideally be prioritized. Since ASHAs are trained after recruitment - once they have already secured the job - they have little motivation to learn. Although it should be noted that at times, highly educated ASHAs do not perform their roles to the best of their ability as they are uninterested in demanding field work for small financial incentives. Hence, it is vital that they receive regular trainings of enhanced quality.⁷⁸

74. Sharma, Reetu, Premila Webster, and Sanghita Bhattacharyya. 2014. "Factors Affecting The Performance Of Community Health Workers In India: A Multi-Stakeholder Perspective". *Global Health Action* 7 (1): 25352. doi:10.3402/gha.v7.25352.

75. *ibid.*

76. Press Information Bureau (Government of India), Ministry of Health and Family Welfare. 2015. "Evaluation Of Accredited Social Health Activists (ASHA)". <http://pib.nic.in/newsite/PrintRelease.aspx?relid=116029>.

77. Salve, Prachi, and Swagata Yadavar. 2017. "India's Health Workers Lack Adequate Training, Decent Pay". *Indiawest*, 2017. http://www.indiawest.com/life_and_style/health_beauty/india-s-health-workers-lack-adequate-training-decent-pay/article_fa9ed856-3cee-11e7-b326-e3852c23935a.html.

78. KJ, Shashank, and Mahabaleshwar Angadi. 2015. "A Study To Evaluate The Knowledge Of ASHA Workers On Antenatal And Postnatal Care In Bijapur District". *International Journal Of Research In Medical Sciences* 3 (9): 2299-2302. doi:10.18203/2320-6012.ijrms20150620.

Institutional, Infrastructural and Organizational Factors

Another key obstacle that health workers face in carrying out their roles stems from lack of institutional and infrastructural support. Often, ASHAs do not receive the mandated supplies that they need to help people.⁷⁹ All ASHAs are supposed to be equipped with medical kits which contain essentials like a delivery kit, a BP monitor, condoms and drugs such as paracetamol, chloroquine zinc tablets, iron folic acid tablets and ORS. Along with this, all ASHAs are supposed to be provided indispensable products like mobile phones, torch lights, and radio which enable them to be functional in their communities.⁸⁰ Lack of regular refurbishments of medical kits affects their ability to perform their roles. For instance, Safiya Begum, an ASHA worker for the Jafrabad area of Delhi told HRLN's fact finding team that they never received condoms from public health centers (PHCs) to distribute to the masses. Although condoms were available at the dispensaries, they were not provided to the ASHAs to carry during field visits.

Another key role of ASHAs is facilitating access to health care centers for pregnant women. However, PHCs are usually understaffed and ill-equipped, and thus not functional. Labour rooms are not comfortable for mothers. Studies show that some district hospitals have no attached bathrooms, no oxygen supply, no blood bank and no functional operation theatres.⁸¹ Lack of transport to and from facilities is a key barrier in facilitating access, particularly during emergencies.⁸² On this account, it becomes difficult for ASHAs to recommend pregnant mothers to opt for an institutional delivery at such PHCs. On the other hand, services of ASHAs and ANMs can be accessed at any time, even in the remote and peripheral areas. Hence health workers are in high demand in such regions. However, they must have all vital tools and support as well as essential training to be effective.

Additionally, organizational factors like a lack of proper guidelines and job descriptions only cause confusion for health workers. There is poor supervision and no accountability for

79. Gupta, Adyya, Jasmine Fledderjohann, Hanimi Reddy, V. R. Raman, David Stuckler, and Sukumar Vellakkal. 2018. "Barriers And Prospects Of India'S Conditional Cash Transfer Program To Promote Institutional Delivery Care: A Qualitative Analysis Of The Supply-Side Perspectives". *BMC Health Services Research* 18 (1). doi:10.1186/s12913-018-2849-8.

80. Ministry of Health & Family Welfare, Government of India. "About ASHA - Government of India." National Rural Health Mission. Accessed February 05, 2018. <http://nhm.gov.in/communitisation/asha/about-asha.html>.

81. Saprii, Lipekho, Esther Richards, Puni Kokho, and Sally Theobald. "Community health workers in rural India: analysing the opportunities and challenges Accredited Social Health Activists (ASHAs) face in realising their multiple roles." *Human resources for health* 13, no. 1 (2015): 95.

82. Gupta, Adyya, Jasmine Fledderjohann, Hanimi Reddy, V. R. Raman, David Stuckler, and Sukumar Vellakkal. 2018. "Barriers And Prospects Of India'S Conditional Cash Transfer Program To Promote Institutional Delivery Care: A Qualitative Analysis Of The Supply-Side Perspectives". *BMC Health Services Research* 18 (1). doi:10.1186/s12913-018-2849-8.

ASHAs. They can essentially work as they please, in accordance with their understanding of the role that they are meant to play. There is no monitoring of their attendance with records being easily forged which encourages non-compliance and non-performances. They are meant to report to multiple supervisors. This requires additional work - attending multiple monthly meetings and preparing duplicate reports. This requires additional time and effort from ASHA workers. It also adds to the confusion due to a lack of coordination between different departments and contradictory instructions from supervisors. Ultimately, it results in a lack of control by either department, or thus, no accountability.

Gender and Tradition

Ground level health workers are repeatedly challenged by the existing social and cultural norms and limit their capacity to fulfill their roles. By tradition, the society often neglects opinions of women and does not welcome their participation in community matters of decision making processes. Hence, it is not an easy task for ASHAs to initiate community action in their capacity as activists and at times, to even advise women on maternal health. Topics like contraception are all the more difficult to discuss as at times, couples are unwilling to openly discuss use of alternate methods of contraception, such as condoms and IUDs, as well as unconventional procedures like male sterilization with ASHAs.

Here, male health workers (MHWs) can play a crucial role. They can surpass the persisting gender inequities and play a dominant role in decision making for reproductive health. They can counsel men about maternal health issues and encourage them to be active participants in contraceptive decisions as well as support female health workers in their tasks so as to overcome traditional and physical (mobility and security) barriers.⁸³ However, the 2017 Rural Health Statistics Report shows that India has a shortfall of 63.7 percent male health workers in sub-centers (or 99,572 male health workers of the required 1,56,231).⁸⁴

Traditional and gender based barriers also stem from the family background of ASHAs as well. As women, ASHAs are expected to perform all household chores like caring for their children, spouses as well as in-laws. They are forced to prioritize their domestic role over their professional responsibilities, as failure to do so causes them reproach from their

83. Fotso, Jean Christophe, Ariel Higgins-Steele, and Satyanarayan Mohanty. 2015. "Male Engagement As A Strategy To Improve Utilization And Community-Based Delivery Of Maternal, Newborn And Child Health Services: Evidence From An Intervention In Odisha, India". *BMC Health Services Research* 15 (S1). doi:10.1186/1472-6963-15-s1-s5.

84. Ministry of Health and Family Welfare (Statistics Division), Government of India. 2018. "Rural Health Statistics: Chapter IV. Health Manpower In Rural Areas". New Delhi: Health Management Information System - A Digital Initiative under National Health Mission.

families. Notably, when ASHAs belong to lower castes are frequently discriminated against by both co-workers and the communities they serve, thus hindering their work performance.

Difficult External Environment and Physical Mobility

The last key factor that deters ground level health workers from fulfilling their roles is their physical work environment. Often, villages are located in rough geographical terrain and do not have proper road connectivity and transportation system, making it extremely difficult for health workers to provide services. In Arunachal Pradesh, ASHA workers are forced to face travelling miles on foot by means of muddy and unfinished roads passing through dense forests full of wild animals; washed out bridges; waiting hours to cross a river via boats; and the uncertainty of being able to return home safely, on a regular basis.⁸⁵ There are limited ambulance services for ASHAs, but even then, ambulances frequently get stuck during heavy rain forcing them to wait hours for a rescue. Arunachal Pradesh has an area of almost 84,000 km²⁸⁶, a population of almost 14 Lakhs⁸⁷, and one of the toughest geographical terrains to navigate in India. Even today, approximately 70 percent of the total area remains sequestered and shockingly hard to reach.⁸⁸

Personal security thus becomes a key concern for ground level health workers. Conflicts between non-state armed groups (like Naxals) and state authorities frequently cause curfews, disruption of existing transport systems and road closures, limiting physical mobility and making provision of emergency healthcare services in remote areas extremely difficult.⁸⁹

Access to Adequate Nutrition

A good level of maternal nutrition not only promotes overall health, productivity and welfare of women but is also a crucial contributor to survival of both women and children. There are two key ways through which lack of adequate nutrition affects maternal mortality

85. Dutta, Rupesh. 2016. "How ASHA Workers Helped Save Lives Of Ethnic Tribes In Arunachal Pradesh". *Daily World*, 2016. <https://dailyworld.in/how-asha-workers-helped-save-lives-of-ethnic-tribes-in-arunachal-pradesh/>.

86. O. Lodrick, Deryck. 2017. "Arunachal Pradesh". *Encyclopaedia Britannica*. <https://www.britannica.com/place/Arunachal-Pradesh>.

87. Chandramouli, C., and Registrar General. "Census of India 2011." *Provisional Population Totals*. New Delhi: Government of India (2011).

88. Dutta, Rupesh. 2016. "How ASHA Workers Helped Save Lives Of Ethnic Tribes In Arunachal Pradesh". *Daily World*, 2016. <https://dailyworld.in/how-asha-workers-helped-save-lives-of-ethnic-tribes-in-arunachal-pradesh/>.

89. Saprii, Lipekho, Esther Richards, Puni Kokho, and Sally Theobald. "Community health workers in rural India: analyzing the opportunities and challenges Accredited Social Health Activists (ASHAs) face in realizing their multiple roles." *Human resources for health* 13, no. 1 (2015): 95.

and morbidity: Anemia and Calcium deficiency.⁹⁰

Anemia is a condition in which one's blood has a low red blood cell count (or hemoglobin) which hinders transport of oxygen to cells in the body. Severe anemia poses a significantly high risk of death for women of reproductive age, whether they are pregnant or not. Pregnancy only enhances the risks associated with anemia, such as that of iron deficiency. Women with anemia are eight times more likely to die than those with normal hemoglobin levels.⁹¹ Anemia leads to postpartum hemorrhage.

In India, according to NFHS-4⁹², 50 percent of pregnant women between the ages of 15 and 49 years were found to be anemic. Anemia is linked to increased blood loss during delivery and puts women at risk of Postpartum Hemorrhage (PPH).⁹³ PPH refers to blood loss of more than 500 ml following vaginal delivery or of more than 1000 ml in case of a cesarean section, within the first 24 hours. It is the leading cause for maternal mortality globally, accounting for 20 percent of maternal deaths⁹⁴ or 127,000 deaths yearly.⁹⁵ In India, hemorrhage is responsible for 19.9 percent of maternal mortality. This number is much higher in some states. For instance, in North-eastern region of India, hemorrhage contributes to 53.19 percent of deaths.⁹⁶ In Delhi, hemorrhage accounts for 22.7 percent maternal deaths⁹⁷ and in Orissa, the number is even higher at 28.57 percent⁹⁸. Serious illnesses such as malaria infection and shorter birth intervals interact with anemia and increase the risk of mortality.

90. US AID. 2018. "Role Of Nutrition In Preventing Child And Maternal Deaths: Multi-Sectoral Nutrition Strategy 2014–2025 Technical Guidance Brief". US AID.

91. Ronsmans, Carine, Simon Collin, and Véronique Filippi. "Maternal mortality in developing countries." In *Nutrition and health in developing countries*, pp. 33-62. Humana Press, 2008.

92. *ibid.*

93. Kavle, Justine A., Rebecca J. Stoltzfus, Frank Witter, James M. Tielsch, Sabra S. Khalfan, and Laura E. Caulfield. "Association between anaemia during pregnancy and blood loss at and after delivery among women with vaginal births in Pemba Island, Zanzibar, Tanzania." *Journal of health, population, and nutrition* 26, no. 2 (2008): 232.

94. Black, Robert E, Lindsay H Allen, Zulfiqar A Bhutta, Laura E Caulfield, Mercedes de Onis, Majid Ezzati, Colin Mathers, and Juan Rivera. 2008. "Maternal And Child Undernutrition: Global And Regional Exposures And Health Consequences". *The Lancet Maternal and Child Health Series* 371 (9608): 243-260. doi:10.1016/s0140-6736(07)61690-0.

95. Kumar, Naina. 2016. "Postpartum Hemorrhage; A Major Killer Of Woman: Review Of Current Scenario". *Obstetrics & Gynecology International Journal* 4 (4). doi:10.15406/ogij.2016.04.00116.

96. Devi, K. Pratima, L. Ranjit Singh, L. Bimolchandra Singh, M. Rameshwar Singh, and N. Nabakishore Singh. 2015. "Postpartum Hemorrhage And Maternal Deaths In North East India". *Open Journal Of Obstetrics And Gynecology* 05 (11): 635-638. doi:10.4236/ojog.2015.511089.

97. Kumar, Naina. 2016. "Postpartum Hemorrhage; A Major Killer Of Woman: Review Of Current Scenario". *Obstetrics & Gynecology International Journal* 4 (4). doi:10.15406/ogij.2016.04.00116.

98. Ramachandra Bhat, PoornimaB, MaheshaH Navada, SujayaV Rao, and G Nagarathna. 2013. "Evaluation Of Obstetric Admissions To Intensive Care Unit Of A Tertiary Referral Center In Coastal India". *Indian Journal Of Critical Care Medicine* 17 (1): 34. doi:10.4103/0972-5229.112156.



More than 80 children died because of malnourishment in a hospital situated in the district of Gorakhpur, Uttar Pradesh

PPH is a preventable condition and caused largely due to complications arising from preexisting anemia, which in turn is a result of lack of adequate nutrition. Death can be prevented through timely interference, efficiency and visor of medical practitioners. It requires women (as well as their spouses and families) be informed of the risks involved with pregnancy and precautions they must take to maintain their health. This requires counselling of pregnant women by ground-level health workers like ASHAs or ANMs regarding importance of good nutrition. This must be combined with adequate access to properly equipped health facilities.



Consistent negligence of the medical authorities at BRD Medical College Hospital, a Government hospital, led to the untimely death of more than 60 children.

Therefore, interventions and preventive measures are crucial in reducing risk of mortality and morbidity. Increasing iron uptake and addressing micronutrient deficiencies can potentially prevent at least half of all anemia cases. “Nutrition-sensitive interventions that increase dietary diversity and improve regular consumption of iron-rich food sources and iron-fortified foods are also important interventions for maintaining iron levels throughout the life cycle.”⁹⁹

The second condition caused by lack of adequate nutrition is low calcium intake which leads to gestational hypertension, meaning, high blood pressure during pregnancy. This can lead to pre-eclampsia - currently recognized as the second most common cause of maternal mortality worldwide.¹⁰⁰ Provision of regular calcium supplements can reduce the risk of pre-eclampsia by 55 percent; the risk of a preterm birth by 24 percent; and the risk of foetal growth constraints.¹⁰¹

Merely access of essential micronutrient supplements like that for vitamin A and zinc from adolescence age can have significant benefits for women and children. Studies show that underweight pregnant women have a higher risk of maternal mortality, difficult labour and need for Cesarean section.¹⁰² In India, poor nutrition is a major concern. The National Family Health Survey (NFHS-4) conducted in 2015-16 revealed that in states of Bihar, Madhya Pradesh and Meghalaya; more than 40 percent of children had stunted growth (low height-for-age) and were visibly malnourished. Moreover, all States and Union Territories report an extremely high rate of wasting (low weight-for-height) in children.¹⁰³ Evidence strongly suggests that both stunting and wasting of women are associated with an increased risk of infants being born small for their gestational age.¹⁰⁴

99. US AID. 2018. “Role Of Nutrition In Preventing Child And Maternal Deaths: Multi-Sectoral Nutrition Strategy 2014–2025 Technical Guidance Brief”. US AID.

100. Black, Robert E, Cesar G Victora, Susan P Walker, Zulfiqar A Bhutta, Parul Christian, Mercedes de Onis, and Majid Ezzati et al. 2013. “Maternal And Child Undernutrition And Overweight In Low-Income And Middle-Income Countries”. *The Lancet* 382 (9890): 427-451. doi:10.1016/s0140-6736(13)60937-x.

101. Bhutta, Zulfiqar A, Jai K Das, Arjumand Rizvi, Michelle F Gaffey, Neff Walker, Susan Horton, Patrick Webb, Anna Lartey, and Robert E Black. 2013. “Evidence-Based Interventions For Improvement Of Maternal And Child Nutrition: What Can Be Done And At What Cost?”. *The Lancet Maternal and Child Health Series* 382 (9890): 452-477. doi:10.1016/s0140-6736(13)60996-4.

102. United Nation Children’s Fund. “Ready-to-use therapeutic food for children with severe acute malnutrition.” Position Paper, no. 1 (June 2013). Accessed February 28, 2018. https://www.unicef.org/media/files/Position_Paper_Ready-to-use_therapeutic_food_for_children_with_severe_acute_malnutrition__June_2013.pdf.

103. Sheet, India Fact. “NFHS-4 (National Family Health Survey-4).” *International Institute for Population Studies* (2017).

104. Black, Robert E, Cesar G Victora, Susan P Walker, Zulfiqar A Bhutta, Parul Christian, Mercedes de Onis, and Majid Ezzati et al. 2013. “Maternal And Child Undernutrition And Overweight In Low-Income And Middle-Income Countries”. *The Lancet* 382 (9890): 427-451. doi:10.1016/s0140-6736(13)60937-x.

REPRODUCTIVE JUSTICE

The term ‘Reproductive Justice’ is frequently treated as synonymous with ‘Reproductive Rights’. However, these terms are philosophically distinct and rooted in different analyses, strategies and constituencies. While reproductive rights talks about one’s right to access healthcare services like that of birth control, safe abortion and nutrition; it is reproductive justice which links reproductive rights to social, political and economic inequalities that hinder a woman’s ability to access these healthcare services.¹⁰⁵ The provision of a right is redundant unless one can avail one’s entitlement under the right and access necessary services. And for this, reproductive justice is critical. The core components of reproductive justice include (but are not limited to) gender equality, freedom from sexual violence, comprehensive sex education, access to affordable contraceptives, family planning services and equal access to safe abortion services.¹⁰⁶

Reproductive justice is essentially an intersectional theory which emerged from the experiences of women of colour and marginalized women as they faced complex issues in the oppression of their reproductive rights.¹⁰⁷ The Asian Communities for Reproductive Justice (ACJR) define reproductive justice as the ‘complete physical, mental, spiritual, political, social and economic wellbeing of women and girls, based on the full achievement and protection of women’s human rights’.¹⁰⁸

Although laws and programmes exist to provide reproductive rights and services to women, the reality is that a vast majority of women cannot access these services for a myriad of reasons. How can a woman who has never been counselled regarding her reproductive choices and the birth control options available to her be expected to provide informed consent for sterilization procedures? Although the law allows for abortions until the 24th gestational week of a pregnancy, how can a woman access these services if none are available in her vicinity? How can a woman working to feed her family afford to take time off to

105. Ahmed, Osub, and Christy Gamble. 2018. “Reproductive Justice: What It Means And Why It Matters (Now, More Than Ever) - Black Women’s Health Imperative”. *Public Health Post*, 2018. <https://www.publichealthpost.org/viewpoints/reproductive-justice/>.

106. *ibid.*

107. Ross, Loretta J. 2017. “Reproductive Justice As Intersectional Feminist Activism”. *Souls* 19 (3): 286-314. doi :10.1080/10999949.2017.1389634.

Ross, Loretta. 2018. “What Is Reproductive Justice?”. In *Reproductive Justice Briefing Book: A Primer On Reproductive Justice And Social Change*. Berkeley Law. <https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051>.

108. Asian Communities for Reproductive Justice, and SisterSong Women of Color Reproductive Health Collective. 2018. *A New Vision - For Advancing Our Movement For Reproductive Health, Reproductive Rights And Reproductive Justice*. Ebook. Oakland, California: Asian Communities for Reproductive Justice. <https://forwardtogether.org/wp-content/uploads/2017/12/ACRJ-A-New-Vision.pdf>.

travel hundreds of kilometers to access services like birth control and safe abortion? How can a woman denied primary education and married as a child be expected to safeguard her reproductive rights and choices against pressures from her husband and in-laws? These are some of the key questions women face as implementation of policies restrict or hinder a woman's access to the reproductive healthcare system.

Moreover, there exists a sharp disparity in the access to healthcare services between urban women and those from remote areas or poor and marginalized groups. There is a significant discrepancy in accessibility of sex education, proper healthcare, education and prevention of sexually transmitted diseases, equate family planning services and safe abortion services for poor and marginalized persons. Furthermore, such communities encounter a substantial lack of quality in services, even when they are available. Healthcare is the influenced by external factors like economical status of the woman and her family; her level of education; and her social situation. Hence, the privacy, moral agency and the ability of these women to take decisions regarding their health and reproductive choices is constricted and severely compromised.¹⁰⁹

Therefore, the framework of reproductive justice analyses how the ability of a woman to make independent choices regarding her reproductive choices is directly related to the conditions of the community she lives in. These extend beyond the ability and access that a woman has to reproductive healthcare services to include the inherent inequity of power that exists within our societies, communities, institutions, environment, economics and culture.¹¹⁰ The central theme in the discourse of reproductive justice remains the control and exploitation of women's bodies, sexuality and reproduction as a means to control and suppress women. Ultimately, control over a woman's body, sexuality and reproduction translates to control over her life, her choices and her potential. It strips her of her power over the options available and her right to self-determination. ACRJ argues that this systematic and institutionalized controlling of women becomes a strategic pathway to regulate the entire community.¹¹¹ Hence, reproductive justice is not solely limited to reproductive rights of women but expands to engage with a diverse set of issues related to

109. Ross, Loretta. 2018. "What Is Reproductive Justice?". In *Reproductive Justice Briefing Book: A Primer On Reproductive Justice And Social Change*. Berkeley Law. <https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fileID=4051>.

110. Asian Communities for Reproductive Justice, and SisterSong Women of Color Reproductive Health Collective. 2018. *A New Vision - For Advancing Our Movement For Reproductive Health, Reproductive Rights And Reproductive Justice*. Ebook. Oakland, California: Asian Communities for Reproductive Justice. <https://forwardtogether.org/wp-content/uploads/2017/12/ACRJ-A-New-Vision.pdf>.

111. *ibid*.

sex trafficking, youth empowerment educational justice, domestic violence, discrimination against transgendered and queer persons, unsafe working conditions, immigrant rights, environmental justice, and globalization.¹¹² Therefore, the strategy to combat this inherent power inequity and envisioned solutions to achieve reproductive justice must be just as diverse and comprehensive. They must focus on all issues of social justice and human rights that impact a woman's body, sexuality and reproduction.

Since the reproductive justice movement looks towards changing the very power relations that currently exist in our society and our institutions, it requires persons to adopt a world view diametrically opposite of the status quo. Hence, this requires taking action through campaigning as well as through legal pathways against those in power to impact real and immediate change. Ultimately, the aim is that women and girls attain the necessary economic, social and political power as well as the resources to make decisions with regards to their body, sexuality, reproduction and consequently, their lives.

112. *ibid.*

Legal Protections and Schemes in India

The Government of India and the State Governments have passed laws and developed schemes and programmes to address issues related to reproductive rights which have been outlined in the previous sections of this book.

The Constitution of India provides fundamental rights and protections for all Indians. It highlights the Right to Life as well as derivative rights such as the right to health and the right to be free from cruel, inhuman and degrading treatment. Furthermore, constitutional and legal rights also address discrimination against women, human trafficking, safe and human working conditions, political reservation, practices derogatory to women, child marriages, abortions and sex selection. To correct persisting violations of fundamental rights of women, the Central and State Governments have also introduced number of schemes to improve the existing reproductive rights situation in India and provide better access to reproductive justice. The following section will briefly introduce the existing protections (constitutional and legal rights) and schemes in the country.

Constitutional Rights

Article 14

Article 14 of the Indian Constitution guarantees the right to 'equality before the law or the equal protection of the laws within the territory of India' to any person within the territory of India. Here, equality before the law is a dynamic concept with multiple facets. It dictates that there should be no privileged person or class and that no person shall be treated as

being above the law. It obligates the State to use existing machinery for the creation of a more equal society. The Article uses the phrase 'any person' to indicate that all individuals, whether citizens of the country or aliens are entitled to the protection provided under the article.

Article 15

Article 15 of the Indian Constitution prohibits discrimination on grounds of religion, race, caste, sex or place of birth, thus adding on to protections under Article 14. It authorizes the government to make special provisions for women and children as well as for economically and socially backward classes under Clause 3. Since reproductive rights issues disproportionately affect women, this Article allows, and demands, that there be special protections in place to safeguard women's lives, health and status. Therefore, it is the responsibility of the Government of India to set up schemes and programs which allow women access to reproductive justice and combat issues like a lack of adequate health infrastructure, non-implementation of government schemes and lack of effective government action.

Article 16

Building on Articles 14 and 15 of the Constitution of India, Article 16 states that: "(1) there shall be equality of opportunity for all citizens in matters relating to employment or appointment to any office under the State. (2) No citizen shall, on grounds only of religion, race, caste, sex, descent, place of birth, residence or any of them, be ineligible for, or discriminated against in respect of, any employment or office under the State." This provision can invoke in cases where women are discriminated against in places of employment due to their sex. For instance, interview questions for female candidates for a job include queries regarding their plans for having children. In some cases, women are fired due to pregnancies, or for having diseases like HIV/AIDS.

Furthermore, article 16 provides a provision for positive discrimination in the form of reservations. Aristotle argued in his discourse of Distributive Justice, injustice prevails when unequals have equal shares and opportunities.¹ Following this premise, the Article allows for reservation of marginalized classes of the society in order to enable them an equal footing and access to opportunities. Therefore, legal provisions are made able for women, guaranteeing them an equal chance to access opportunities of employment.

1. Aristotle. 2006. *A New Translation Of The Nichomachean Ethics Of Aristotle*. [London, England]: [Hesperides Press].

Article 21

Article 21 of the Indian Constitution states that: “No person shall be deprived of his life or personal liberty except according to a procedure established by law.” This provision acts as a cornerstone of the democratic society of India and is held to be the heart of the Constitution. The Article has been cited in numerous cases related to reproductive rights issues. It can be interpreted in a broad manner to include a number of other derivative rights. The Article covers the following two rights.

- **Right to Life:** The right to life is the most fundamental right and forms the crux of the broad interpretation of Article 21. All other derivative rights add to quality of life in question and therefore only have utility due to the primary right to life. ‘Life’ does not merely constitute the physical act of breathing or an animal existence and a life of drudgery. It includes the right to live a life of dignity, the right to health, the right to medical care, the right to a livelihood, the right to social security and protection of family, the right to a clean and pollution free environment and the right to be informed. The right to life includes the right to a meaningful and a fulfilling existence.

A key derivative right under Article 21 is the right to a life with human dignity and all that goes along with it - bare necessities such as access to adequate nutrition, clothing, and shelter - as minimum requirements to a chief a life with dignity. This right extends to the fundamental right to health and medical care as they are crucial ensure an individual’s right to a life with human dignity.² Hence, the Article is frequently cited when it comes to reproductive rights violations. Issues like that of maternal mortality stem from a violation of a woman’s right to health and are thus a violation of the right to life. If a woman has a forced abortion, she has been subjected to inhuman treatment. If a woman is forced to give birth in public conditions due to refusal from hospitals to provide emergency aid, it is a violation of her right to health and dignity.

In *Consumer Education and Research Centre V. Union of India*, the Supreme Court stated that: “*Social justice which is device to ensure life to be meaningful and liveable with human dignity requires the State to provide to workmen facilities and opportunities to reach at least minimum standard of health, economic security and civilized living. The health and strength of worker, the court said, was an important facet of right to life. Denial thereof denudes the workmen the finer facets of life violating Art. 21.*”³

2. Mathiharan, K. “The fundamental right to health care.” *Issues Med Ethics* 11 (2003): 123.

3. *Consumer Education and Research Centre v. Union of India*. 1995. 1995 AIR 922, 1995 SCC (3) 42. Bench: Ramaswamy, K. Supreme Court of India.

Building on to the right to health, the right to access medical care is also encompassed within Article 21's right to life. It is the obligation of the State and those in charge of healthcare to preserve life. No law, state or medical authority can delay the discharge of medical care. Nevertheless, hospitals and doctors often refuse treatment to poor and marginalized communities under pretences that they do not possess adequate facility and infrastructure. In such matters, Article 21 may be cited as an individual's fundamental right to life includes his right to access adequate medical care. The State has the responsibility to provide resources which enable people to access their entitlements under this fundamental provision. No hospital should refuse treatment on the basis that a patient cannot afford the expenses associated.

- **Right to Personal Liberty:** The right to personal liberty in the Indian Constitution is the right to be free from restrictions or encroachments, whether they are direct or indirectly imposed. The Supreme Court of India has laid down that under Article 21; the right to personal liberty encompasses all those protections and privileges that are recognized as being crucial to the 'orderly pursuits of happiness by free men'⁴.

The Supreme Court of India unanimously declared the right to privacy, an essential provision under the right to personal liberty, as a guaranteed fundamental right in August 2017.⁵ Therefore, a citizen has the fundamental right to privacy in matters of one's health, family, marriage, personal intimacies, procreation, motherhood, childbearing and sexual orientation, among others.⁶ The right to privacy thus extends to the health sector. Patients have a right to privacy in their consultations with doctors, in their counselling and their decision making process. Therefore, a woman has a fundamental right to privacy in taking decisions pertaining to her reproductive choices.⁷ She has the right to refuse participation in sexual activity; the right to insist on the use of contraception; the right to choose a method of contraception amongst the ones available such as condoms, IUDs, sterilizations or Injectable contraceptives; the right to make decisions with respect to a pregnancy.

4. Jain, Riya. 2015. "Article 21 Of The Constitution Of India - Right To Life And Personal Liberty". *Academike - Articles On Legal Issues*. <https://www.lawctopus.com/academike/article-21-of-the-constitution-of-india-right-to-life-and-personal-liberty/>.

5. Hindustan Times. 2017. "Full Text Of Supreme Court'S Judgment On Right To Privacy", , 2017. <https://www.hindustantimes.com/india-news/supreme-court-rules-privacy-is-fundamental-right-here-s-full-text-of-the-judgment/story-Wheiu7B8nbgbtJYT1KzkO.html>.

6. *ibid*.

7. Jain, Riya. 2015. "Article 21 Of The Constitution Of India - Right To Life And Personal Liberty". *Academike - Articles On Legal Issues*. <https://www.lawctopus.com/academike/article-21-of-the-constitution-of-india-right-to-life-and-personal-liberty/>.

Hence, the fundamental right to privacy may be cited in cases pertaining to the protection of a woman's health.

Article 42

This Article of the Indian Constitution guarantees the provision of 'just and humane conditions' at workplaces along with maternity relief for women in the form of paid maternity leave. The Article covers all female workers, is intended to preserve social justice for women in employment requiring physical labour, enabling them to maintain their energy to nurse their child and thus preserving her previous efficiency and output.⁸

Article 46

Article 46 of the Constitution of India states that: "The State shall promote with special care the educational and economic interests of the weaker sections of the people, and, in particular, of the Scheduled Castes and the Scheduled Tribes, and shall protect them from social injustice and all forms of exploitation." This article is applicable to all sections of the population who suffer from backwardness similar to those from Scheduled Castes and Scheduled Tribes due to educational and economic reasons, even if they do not belong to these categories (like women).⁹

Article 47

Article 47 of the Indian Constitution lays down that: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health." Maternal mortality is largely associated with lack of access to adequate nutrition which leads to problems such as anemia and low calcium levels - conditions presenting significant risks to pregnant women and babies (as discussed earlier in this book - see section titled 'Access to Adequate Nutrition'). Such cases may invoke Article 47 to uphold the State to its primary responsibility of providing access to adequate levels of nutrition.

8. B. Shah vs Presiding Officer, Labour Court, Coimbatore. 1977. 1978 AIR 12, 1978 SCR (1) 701. Bench: Singh, Jaswant. Supreme Court of India.

9. Janki Prasad Parimoo & Ors. Etc. v. State Of Jammu & Kashmir & Ors. 1973. 1973 AIR 930, 1973 SCR (3) 236. Bench: Sikri, S.M. (Cj), Ray, A.N., Palekar, D.G., Beg, M. Hameedullah, Dwivedi, S.N. Supreme Court of India.

M. R. Balaji And Others v. State Of Mysore. 1962. 1963 AIR 649, 1962 SCR Supl. (1) 439. Bench: Sinha, Bhuvneshwar P.(Cj), Gajendragadkar, P.B., Wanchoo, K.N., Gupta, K.C. Das, Shah, J.C. Supreme Court of India.

Indian Penal Code (1860)

The Indian Penal Code is a comprehensive code which outlines violations and offences and covers all substantive aspects of criminal law. It outlines sexual assaults including rape (Section 375) and the punishment for it (Section 376). Other Sections which may be applicable to cases pertaining to reproductive rights include: offences causing miscarriages or injuries to unborn children (Section 312); medical malpractice (Section 52, 80, 81, 83, 88, 92, 304A, 337 and 338); fraud or cheating (Section 420); the constitution of consent free from fear of injury or under a misconception (Section 90).¹⁰ The sections on medical malpractice may be cited in cases pertaining to maternal mortality, refusal of treatment due to patients' lack of ability to pay for expenses incurred, discrimination against HIV positive pregnant women such denial of emergency medical care or assistance in delivery, cases of botched abortions, cases of botched sterilization surgeries and so on. Sections on fraud and consent may also be used in cases where women are coerced into opting for sterilization procedures without proper counselling and without being adequately informed of what the procedure entails, the risks associated with the surgery and alternate contraceptives available.

Legislative Rights

Maternity Benefit Act (1961)

The Maternity Benefit Act guarantees a mandatory fully paid maternity leave to all women employed in the public sector for childbirth and to take care of the newborn baby. It ensures continuation of employment after childbirth and prohibits termination of employment of women based on availing of maternal benefits. The Act is applicable to women working in sectors such as mines, plantations, shops, establishments and factories, whether it is organized or unorganized.¹¹

The Maternity Benefit (Amendment) Act, 2017, was passed on 27th March 2017 to make the following amendments¹²:

10. Government of India. 1860. "The Indian Penal Code."

11. Meena, H.L. 2017. "The Maternity Benefit (Amendment) Act, 2017". New Delhi: Ministry of Labour and Employment. <http://www.livelaw.in/centre-issues-clarifications-regarding-maternity-benefit-amendment-act-2017/>

12. Government of India, Ministry of Law and Justice, Legislative Department. 2017. "The Gazette Of India: The Maternity Benefit (Amendment) Act, 2017 (No. 6 Of 2017)". New Delhi: The Controller of Publications. <https://labour.gov.in/sites/default/files/Maternity%20Benefit%20Amendment%20Act%2C2017%20.pdf>

Press Information Bureau, Government of India (Ministry of Women and Child Development). 2017. "Maternity Benefit (Amendment) Bill, 2016 Passed In The Parliament". <http://pib.nic.in/newsite/PrintRelease.aspx?relid=159039>.

- (a) Extension of maternity leave from 12 weeks to 26 weeks for working women with less than two surviving children.
- (b) Provision of 12 weeks of maternity leave to ‘adopting mothers’ (who are adopting a child below the age of three months) and ‘commissioning mothers’ (who are defined as biological mothers who use their egg to create an embryo which is implanted in another woman).
- (c) Mandatory provision of a crèche facility by all establishments with more than 50 employees, with mothers being allowed to up to four visits to the facility during working hours to look after and feed the child.
- (d) Provision of work from facility where possible for nursing mothers.

The Maternity Benefit Act also allows women to take paid maternity leave in cases of miscarriage, medical termination of pregnancy or for procedures such as tubectomy.

Medical Termination of Pregnancy Act (1971)

The Medical Termination of Pregnancy Act provides for the termination of pregnancies under certain conditions by registered medical practitioners. The situations which allow for abortions are as follows¹³:

- If the length of the pregnancy does not exceed 12 weeks.
- If the length of the pregnancy exceeds 12 weeks but does not exceed 20 weeks and if at least two registered medical practitioners are of the opinion that -
 - If continued, the pregnancy would pose a risk to the life of the pregnant woman or of grave injury to her physical or mental health. To determine this, the woman’s current and reasonable foreseeable environment must be taken into account.
 - There would have been substantial risks that if a child was born, it would suffer from gross physical or mental abnormalities or handicap.
- After the 20th week, a registered medical practitioner may only perform an MTP as an emergency measure to save a woman’s life.
- If the pregnant results from an act of rape. Here, the anguish caused by the pregnancy is presumed to constitute a grave injury to the mental health of the pregnant woman.
- If the pregnancy results due to the failure of a device or method used by married women or their husbands to avoid pregnancy. Here, an unwanted pregnancy may be understood to gravely harm the mental health of the woman in question.

13. Ministry of Health and Family Welfare. 1971. “The Medical Termination Of Pregnancy Act, 1971 (Act No. 34 Of 1971)”. New Delhi: Ministry of Health and Family Welfare. <https://mohfw.gov.in/acts-rules-and-standards-health-sector/acts/mtp-act-1971>

The Act was amended to further add that a pregnancy may only be terminated with the explicit and informed consent of the woman in question. For minors, or those suffering from mental illness, consent must be attained from her guardian.¹⁴ Here, a mentally ill person is defined as one ‘who is in need of treatment by reason of any mental disorder other than mental retardation’.¹⁵ Abortions must be carried out in hospitals government hospitals or one approved for this purpose by the Government and only by registered medical practitioners. Abortion procedures which do not follow these guidelines may be prosecuted under the Indian Penal Code (45 of 1860) with rigorous imprisonment of two to seven years.¹⁶

Although the MTP Act was amended in 2002 to allow for better implementation and increased access to abortion services, unsafe abortions remain prevalent in India. The Act has been criticized championing the medical practitioner’s opinions over the views and needs of the pregnant woman in question.

Furthermore, it has been criticized for not allowing abortions above the gestational age of 20 weeks. Medical and legal experts argue that advancements in medical science and technology have made the 20 week limit redundant.¹⁷ In most cases, foetal abnormality is conclusively determined only after 18 weeks of gestational age. It is therefore unreasonable to ask prospective parents to make decisions regarding abortions in merely two weeks. This only forces women to opt for unqualified practitioners, thus increasing likelihood of unsafe abortions. In 2017, amendments were proposed to increase the gestational age limit for abortion to 24 weeks and allow practitioners of alternative medicine (such as AYUSH and homeopathy practitioners) to carry out abortions using non-surgical methods.¹⁸ This could widen the provider base and provide better access to women seeking abortion services. However, the amendment was not taken up for consideration by the Union Cabinet.

Consumer Protection Act (1986)

The Consumer Protection Act, enacted in 1986, is targeted at preserving the interest of the public. The Act (and its amendments) provides the following rights to consumers¹⁹:

14. Ministry of Health and Family Welfare. 2002. “The Medical Termination Of Pregnancy (Amendment) Act, 2002 (Act No. 64 Of 2002)”. New Delhi: Ministry of Health and Family Welfare. <https://mohfw.gov.in/acts-rules-and-standards-health-sector/acts/mtp-act-amendment-2002>

15. *ibid.*

16. *ibid.*

17. The Hindu. 2017. “Draft Medical Termination Of Pregnancy (Amendment) Bill, 2014”, , 2017. <http://www.thehindu.com/news/national/the-hindu-explains-medical-termination-of-pregnancy-amendment-bill-2014/article18474057.ece>.

18. Ghosh, Abantika. 2018. “Abortion Law Amendments On Hold”. *The Indian Express*, 2018. <http://indianexpress.com/article/india/abortion-law-amendments-on-hold-4693900/>.

19. National Consumer Disputes Redressal Commission, Government of India. 1986. “The Consumer Protection

- (a) Right to be heard and to be assured that consumers' interests will receive due consideration at appropriate forums;
- (b) Right to seek redressal against unfair trade practices or restrictive trade practices or unscrupulous exploitation of consumers;
- (c) Right to consumer education;
- (d) Right to access to a variety of goods and services at competitive prices;
- (e) Right to be informed about the quality, potency, purity, standard and price of goods (or services as the case may be) so as to protect the consumers against unfair trade practices;
- (f) Right to be protected against the marketing of goods (and services) which are hazardous to life and property;

This Act is also applicable to medical services and may be cited in reproductive rights cases with medical negligence. All medical professionals have a duty to provide a reasonable degree of care and a minimum standard of professional behaviour. This does not translate to the highest degree of care or competence. Negligence can be construed when there is absence or lack of care that a reasonable person should have taken in similar circumstances.²⁰

Hospitals have become increasingly money-oriented, requiring emergent patients to make deposits even before they begin examination and treatment. There are instances of bad or incorrect treatment which only aggravate the problem. Recently, a large number of such cases are seeking redressal of their grievances through the courts.²¹ In reproductive rights, cases related to non-consensual medical procedures like hysterectomies and tubectomies, substandard care, and unhygienic facilities may require compensation under the Act.

In *Smt. Savita Garg vs. The Director, National Heart Institute* (2004) 8 SCC 56²², a Division Bench of the Hon'ble Supreme Court held that once a claim petition is filed and the complainant has successfully discharged the initial burden that the hospital/clinic/doctor was negligent, and that as a result of such negligence the patient died, then in that case the burden lies on the hospital and the doctor concerned who treated the patient to show that there was no negligence involved in the treatment. The Bench ruled that it was the responsibility of the medical institution to satisfy that all possible care was taken and no negligence was involved in attending to the patient and burden to prove otherwise could not

Act, 1986 (68 Of 1986)". New Delhi: National Consumer Disputes Redressal Commission. http://ncdr.nic.in/bare_acts/Consumer%20Protection%20Act-1986.html

20. Joga Rao, SV. 2009. "Medical Negligence Liability Under The Consumer Protection Act: A Review Of Judicial Perspective". *Indian Journal Of Urology* 25 (3): 361. doi:10.4103/0970-1591.56205.

21. Gupta, Chhavi. 2015. "Medical Negligence-A Deficiency In Services Under Consumer Protection Act, 1986". *IMS Manthan (The Journal Of Innovations)* 10 (1). doi:10.18701/imsmanthan.v10i1.5657.

22. *Smt. Savita Garg v. The Director, National Heart Institute*. 2004. Appeal (civil) 4024 of 2003. Bench: B.N. Agrawal & A.K. Mathur. Supreme Court of India.

reasonably be placed on the patient. For instance, in a failed sterilization matter *Sumathi v. Dr Suganthi & Ors.* (2014)²³, the Madras High Court stated that the doctrine of *Res ipsa loquitur* would be applicable. Since, failure rate is negligible in sterilization procedures, the initial assumption would be regarding negligence in the operation. Therefore, when there is conception and child birth in spite of undergoing a sterilization operation, the burden to prove standard of care was maintained is shifted to the concerned doctor.

Pre-Conception and Pre-Natal Diagnostic Techniques Act (1994)

The Pre-Conception and Pre-Natal Diagnostic Techniques Act (PCPNDT) provides for the prohibition of sex selection before or after conception through regulation of pre-natal diagnostic techniques meant to detect genetic abnormalities, metabolic disorders, chromosomal abnormalities, congenital malformation or sex linked disorders in order to prevent their misuse for sex determination which can lead to female foeticide.²⁴ This Act was a response to the country's continued disproportionate sex ratio.

Firstly, the Act prohibits genetic laboratories from using any technique which causes sex determination (including sperm sorting). Secondly, it regulates techniques like ultrasonography to determine sex of the foetus. In this case, enforcement relies on reporting from registered testing and genetic facilities. Violation of the PCPNDT Act by medical practitioner can result in imprisonment of up to five years and a fine of up to Rs 50,000.²⁵ Violations by individuals seeking sex determination can be up to three years in prisons and a fine of Rs 50,000. The Act adds that no punishment would apply to the woman who was forced to undergo such diagnostic or election techniques.

The Government controls the sale and regulation of ultrasound machines. The Act also imposes certain regulations with respect to paperwork required to keep records of ultrasound procedures conducted (under Section 29 of the PCPNDT Act).²⁶ Nevertheless, the sex ratio has only worsened with every census and after 20 years of the Act's implementation, it is evident that the Act has not made much headway and has had disappointing results. In 1981, there were 962 girls in the age group of 0-6 years for every thousands boys. This ratio fell to 945 girls in 1991, then to 927 girls in 2001, and to 918 girls according to the 2011

23. *Sumathi v. Dr. Suganthi & Ors.* 2014 JUDGMENT IN S.A. No. 683 of 2006 Delivered on 30.10.2014 Judge: R. Mahadevan, J. Madras High Court.

24. National Commission for Protection of Child Rights (Government of India). 1994. "The Pre-Natal Diagnostic Techniques (Regulation And Prevention Of Misuse) Act, 1994 (Act No. 57 of 1994) and The Pre-Natal Diagnostic Techniques (Regulation And Prevention Of Misuse) Amendment Act, 2002 (No.14 OF 2003)". New Delhi: National Commission for Protection of Child Rights. http://www.ncpcr.gov.in/view_file.php?fid=434

25. *ibid*, para. 23.

26. *ibid*, para. 29.

Census.²⁷ For one, new technology threatens to make regulations under the PCPNDT Act redundant as they have the ability to allow for much earlier sex determination through non-invasive procedures like blood tests.²⁸

Moreover, it can be argued that the PCPNDT Act places undue focus on physicians by placing the moral and legal burden on them rather than the families seeking sex determination with the aim of female foeticide.²⁹ In fact, it should be noted that the Act makes no mention of Medical Termination of Pregnancy (MTP). Hence, if sex of the foetus is determined, any subsequent MTP (for whatever reason it may have been carried out) will not amount to a punishable offence under the PCPNDT Act.

Therefore, the only thing that this Act achieves is that it oversimplifies a complex issue and makes it extremely difficult for medical practitioners to adequately perform their jobs.³⁰ PCPNDT's emphasis on details requires medical practitioners to fill out an essential four page form titled 'Form for Maintenance of Record in Case of Prenatal Diagnostic Test/ Procedure by Genetic Clinic/ Ultrasound Clinic/ Imaging Centre' (referred to as Form F) in triplicate, signed by both the patient and the doctor, before an ultrasound can be performed.

This can be extremely problematic for both doctors and patients. Often, patients are not equipped with the required identity documents when visiting hospitals. Especially in the rural areas, women are frequently not aware of the requirement under the PCPNDT Act and do not possess all the information required to fill out Form F and consequently get an ultrasound. At times, women simply do not possess an identity card. Due to this missing information, patients are forced to go back home and travel all the way back to the hospital, which can be located at considerable distances, thus greatly inconveniencing patients. For daily wage labourers, travelling back to the hospital can mean the loss of an extra day of wages and possibly going hungry that day. Medical practitioners are unwilling to accommodate patients due to the fear of the extremely stringent punishments in place. A mere incomplete address can result in authorities closing down the clinic or sealing the ultrasound machine - undoing which can take months. Larger hospitals (like Fortis) employ personnel solely for the purpose of filling out these forms, however, rural medical centers cannot afford to do so and thus bear the brunt of the problem.³¹

27. Census 2011.

28. Patnaik, A. Murali Mohan, and Gouri Shankar Kejriwal. "A perspective on the PCPNDT Act." *The Indian journal of radiology & imaging* 22, no. 2 (2012): 137.

29. Tabaie, Sheida. 2017. "Stopping Female Feticide In India: The Failure And Unintended Consequence Of Ultrasound Restriction". *Journal Of Global Health* 7 (1). doi:10.7189/jogh.07.010304.

30. *ibid.*

31. Tripathi, Amrita. 2016. "Sex Determination In India: Doctors Tell Their Side Of The Story". *Scroll.in*, 2016. <https://scroll.in/article/805064/sex-determination-in-india-doctors-tell-their-side-of-the-story>.

Ultimately, this Act leads to a significant sacrifice in patient care. A study published through the Edinburgh University Global Health Society found that a vast majority of tertiary care centers did not have access to ultrasounds. A third of these were not compliant with the regulations laid down under the PCPNDT Act.³² “One anesthesiologist cited a delay of nearly two years to obtain an ultrasound due to the PCPNDT registration process.”³³ Ultrasound is vital technology in patient care, especially for pregnant women, and must be widely accessible. Quality of care cannot possibly be maintained if such a vital imaging tool is not accessible to the masses.

Protection of Women from Domestic Violence Act (2005)

The Protection of Women from Domestic Violence Act of 2005 was enacted to provide for more effective protection of women rights guaranteed under the Constitution. It provides a comprehensive definition of domestic violence; outlines the powers and duties of the Government, protection officers, service providers, police officers, magistrates, shelter homes and medical facilities; and stipulates the procedures for obtaining orders of relief.³⁴

“For the purposes of this Act, any act, omission or commission or conduct of the respondent shall constitute domestic violence in case it:

- harms or injures or endangers the health, safety, life, limb or well-being, whether mental or physical, of the aggrieved person or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse and economic abuse;
- harasses, harms, injures or endangers the aggrieved person with a view to coerce her or any other person related to her to meet any unlawful demand for any dowry or other property or valuable security;
- has the effect of threatening the aggrieved person or any person related to her by any conduct mentioned in clause (a) or clause (b);
- other injures or causes harm, whether physical or mental, to the aggrieved person.”

The act encompasses all forms of physical as well as economic abuse. The law casts a wide net and protects wives, live-in partners, sisters, single women, adopted children, daughters, widows and mothers living with the abuser. It also guarantees a woman’s right to housing in her matrimonial home regardless of the property titles or grants. Additionally, it prevents

32. Tabaie, Sheida. 2017. “Stopping Female Feticide In India: The Failure And Unintended Consequence Of Ultrasound Restriction”. *Journal Of Global Health* 7 (1). doi:10.7189/jogh.07.010304.

33. *ibid.*

34. National Commission for Women, Government of India. 2005. “THE PROTECTION OF WOMEN FROM DOMESTIC VIOLENCE ACT, 2005 (ACT NO. 43 OF 2005)”. New Delhi: National Commission for Women. <http://ncw.nic.in/acts/TheProtectionofWomenfromDomesticViolenceAct2005.pdf>

the abusers from seeking contact with the victims or isolating the victim's assets.

Furthermore, in 2016, the Supreme Court of India declared that any person could be tried under this Act. The apex Court ordered the deletion of the words 'adult male person' from the Act as it is contrary to the Act's overall objective of affording protection from violence of any kind.³⁵ Thus, women and minors may be named as respondents and tried under this Act.

Prohibition of Child Marriage Act (2006)

The Prohibition of Child Marriage Act of 2006 replaced the Child Marriage Restraint Act of 1929. The policy was enacted as a response to high maternal mortality and morbidity and the civil society activism, litigation and international attention which followed.³⁶ It provides for the prohibition of solemnization of child marriages.

The Act defines 'child' as any male below the age of 21 and any female below the age of 18. A child marriage occurs when either contracting party is a child.³⁷ The Act stipulates that all child marriages may be voided at any time by either child contracting party. A child marriage is also considered null and void under the following circumstances³⁸:

- Where a child is taken or enticed out of the keeping of the lawful guardian;
- Where a child is by force compelled, or by any deceitful means induced to go from any place;
- Where a child is sold for the purpose of marriage; and made to go through a form of marriage or if the minor is married after which the minor is sold or trafficked or used for immoral purposes;

Moreover, the Act lists stringent punishments for males above the age of 18 who are knowingly party to child marriages. It also provides for punishments for solemnizing a child marriage and for promoting or permitting child marriages. The Act allows Courts to give orders directing the groom or his family to pay for maintenance to the bride until her remarriage in cases where the marriage has been declared void.

Furthermore, the Act provides for the appointment of 'Child Marriage Prohibition

35. The Indian Express. 2016. "Any Person Can Now Be Tried Under Domestic Violence Act: Supreme Court", 2016. <http://indianexpress.com/article/india/india-news-india/any-person-can-now-be-tried-under-domestic-violence-act-supreme-court-3073359/>.

36. National Commission for Women, Government of India. 2007. "THE PROHIBITION OF CHILD MARRIAGE ACT, 2006 (ACT NO. 6 OF 2007)". New Delhi: National Commission for Women. <http://ncw.nic.in/acts/pcma2006.pdf>

37. *ibid*, para. 2.

38. *ibid*, para. 12.

Officers' (CMPOs)³⁹ in all districts, who are tasked with preventing child marriages, sensitizing the community regarding the perils of child marriages, furnish periodical statistics, and perform other vital duties. CMPOs have the power to seek an injunction from Magistrate judges to halt child marriages.⁴⁰

However, the Act has been criticized for its vague language and loopholes which allow for child marriages to remain valid. For one, it specifically states that child marriage is not void, but only voidable. Thus, if the court determines that the child contracting parties have entered into a marriage willingly, the marriage may remain valid. In reality, the child parties involved are often pressured to enter the marriage by their families and cannot reasonably be expected to petition for a nullification against their family's wishes.

Additionally, the Prohibition of Child Marriage Act (2006) needs to be re-examined in relation to the criminal law provisions under the Indian Penal Code (IPC)⁴¹. The Act fails to address the discrepancy in the age of consent at the time of rape and age of consent for rape within a marriage - which has severe implications for child marriages in India. Lack of recognition of rape of a wife who is 15 years of age or below by her husband effectively restricts the control that women have over their own sexuality. There is a provision of imprisonment of two years for marital rape if the wife is between 12 and 15 years of age. However, for females aged 16 to 18, there exists a grey area between age and agency which the Act must address.⁴²

Sexual Harassment of Women at Workplace - Prevention, Prohibition and Redressal Act (2013)

Popularly referred to as the 'POSH Act', the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act⁴³ of 2013 was India's first piece of legislation to specifically address the issue to workplace sexual harassment. Sexual harassment at workplace creates an insecure, insensitive and hostile working environment for women and hinders their ability to effectively perform their roles. Moreover, it adversely affects their social and economic growth and puts them through emotional and sometimes physical

39. *ibid*, para. 16

40. *ibid*, para. 13.

41. Government of India. 1860. "The Indian Penal Code."

42. "Child Marriages In India: A Critique". 2013. *Law-Projects.Blogspot.In*. <http://law-projects.blogspot.in/2013/12/child-marriages-in-india-critique.html>.

43. Ministry of Women and Child Development, Government of India. 2013. "The Sexual Harassment Of Women At Workplace (Prevention, Prohibition, And Redressal) Act, 2013 (No. 14 Of 2013)". New Delhi: The Gazette of India (Ministry of Law and Justice, Legislative Department). <http://wcd.nic.in/sites/default/files/Sexual-Harassment-at-Workplace-Act.pdf>

suffering.⁴⁴ The POSH Act aims to provide all women (irrespective of their employment, status or age) with a safe, secure and dignified work environment.

However, even though the Act has been in force since 2013, there remains a staggering lack of clarity on salient aspects of the law including what constitutes sexual harassment, obligations of an employer, remedies/safeguards available to the victim, procedure of investigation, etc.

The Act defines 'sexual harassment'⁴⁵ in line with Supreme Court's landmark 'Vishaka Judgement', as direct or implied unwelcome sexually tinted behaviour, such as:

- (a) Physical contact and advances;
- (b) Demand or request for sexual favours;
- (c) Making sexually coloured remarks;
- (d) Showing pornography;
- (e) Any other unwelcome physical, verbal or non-verbal conduct of a sexual nature;

Sexual harassment also encompasses quid pro quo sexual blackmail, i.e., a person in power, pressurizing a woman employee for sexual favours exchange for career advancement or fear from adverse employment action. The Act mandates employers to set up an Internal Complaints Committee (ICC) to hear and redress complaints.

Sexual harassment is a subjective issue and may not always be easily distinguishable. Hence, the Act allows ICC to decide whether the harassment suffered is sufficient severe to have created a hostile work environment. This can often let complaints of harassment go unaddressed.⁴⁶ For instance, what offends women may be considered unobjectionable by men. Men tend to view certain forms of harassment as harmless social interactions or amusements which are only objected to by 'overly-sensitive women'.⁴⁷ Moreover, the Act does not satisfactorily address the issue of accountability. It does not specify who is responsible for ensuring compliance of organizations. This makes effective functioning of the ICC questionable, at best. State governments must take up this function in order for the Act to have any real impact.⁴⁸

44. *ibid*, Statement of Objects and Reasons.

45. *ibid*, Section 2(n).

46. Adak, Baishali. 2015. "Delhi Commission For Women Wants Changes To Sexual Harassment Act As Loopholes See Victims Suffer". *Daily Mail Online India*, 2015. <http://www.dailymail.co.uk/indiahome/indianews/article-3273041/Delhi-Commission-Women-wants-changes-Sexual-Harassment-Act-loopholes-victims-suffer.html>.

47. Nishith Desai Associates. 2018. "India'S Law On Prevention Of Sexual Harassment At The Workplace". Nishith Desai Associates: Legal and Tax Counselling Worldwide. http://www.nishithdesai.com/fileadmin/user_upload/pdfs/Research%20Papers/Prevention_of_Sexual_Harassment_at_Workplace.pdf

48. Saigal, Sonam. 2017. "Sexual Harassment At Work: The Limits Of The Law". *The Hindu*, 2017. <http://www.thehindu.com/news/cities/mumbai/sexual-harassment-at-work-the-limits-of-the-law/article17763605.ece>.

Codified and Un-codified Personal Laws

In India, codified personal laws govern aspects of marriage, divorce, and succession depending on religious affiliation. As a consequence, religious doctrine inevitably plays an essential role in determining applicable law. For example, under these laws, courts have determined that “refusal to reproduce” amounts to cruelty and a legitimate ground for divorce.

National Schemes and Policies related to Reproductive Rights

The Government has introduced numerous schemes which directly address the public health system and consequently reproductive rights as they are encompassed within the fundamental right to health. Key schemes and policies which can be cited in reproductive rights matters are outlined below.

National Rural Health Mission

The National Rural Health Mission (NRHM), a sub-mission of the over-arching National Health Mission (NHM), was launched in April 2005⁴⁹ with the aim of providing accessible and affordable quality health care to rural populations, particularly vulnerable groups like the poor, women and children.⁵⁰ The mission focuses on the establishment of a health care infrastructure which is fully functional, community owned and decentralized. It creates a three tiered system of deliverance of health care with inter-sectoral convergence at all levels to allow for the implementation of a long-term strategy. The levels of healthcare and their obligations are elaborated below.

Sub Health Centers (SHC)

Sub Health Centers are the hub responsible for delivery of health care and effective outreach services in rural areas. At the village level, the Anganwadi Centers often perform the role of sub health centers and act as the ‘first port of call’, thus facilitating access to the community.⁵¹

Hence, they must be easily reachable. There is 1 sub centre per 5,000 populations in

49. Ministry of Health and Family Welfare. 2018. “National Rural Health Mission - Government Of India”. *Nhm.Gov.In*. <http://www.nhm.gov.in/nhm/nrhm.html>.

50. Ministry of Health and Family Welfare - National Health Mission. 2018. “Framework For Implementation (National Health Mission) 2012 - 2017”. New Delhi: Government of India. http://nhm.gov.in/images/pdf/NHM/NHM_Framework_for_Implementation__08-01-2014_.pdf

51. *ibid*, page 14, 15.

general areas and 1 per 3,000 populations in difficult/tribal and hilly areas.⁵² The Central Government has adopted a new norm which dictates that SHCs must be set up based on 'time to care' within 30 minutes by walk from the habitation it will cater to in hilly and desert areas. Generally, SHCs are staffed by one Female Health Worker - the Auxiliary Nurse Midwife (ANM) and one Male Health Worker (referred to as the Multi Purpose Worker).

Obligations of SHCs are listed as follows:

- Early registration of all pregnancies, ideally within the first trimester;
- Minimum of three antenatal checkups: First visit to antenatal clinic as soon as pregnancy is suspected, second between fourth and sixth month (around 26 weeks), third between fourth and ninth month (around 36 weeks);
- Associated general services such as examination of weight and blood pressure; breast examination; and treatment for anemia;
- Provision of supplements including folic acid in the beginning of the first trimester and iron in the beginning of the second trimester;
- Provision of vaccines (including an injection of tetanus toxoid);
- Identification of high-risk pregnancies as well as appropriate and prompt referral;
- A minimum of two postpartum home visits: First, within 48 hours of delivery and second within 7 to 10 days;
- Provision of facilities under Janani Suraksha Yojana (JSY)

Primary Health Centers (PHC)

Primary Health Centers (PHCs) are responsible for overseeing the functioning of all SHCs within its purview. There is 1 PHC per 30,000 populations in general areas and 1 per 20,000 populations in areas with a hilly and difficult/tribal terrain.⁵³ Apart from the availability of bare minimum facilities as under the SHCs, PHCs have an obligation to provide the following:

- 24 hour emergency care including delivery services for both normal and assisted deliveries;
- Full coverage of maternal diseases or health conditions;
- Counselling on diet, pre-birth preparedness and complication readiness; full breast feeding support until the child is weaned off at six months; advice on institutional

52. "Infrastructure - Government Of India". 2018. *Nhm.Gov.In*. <http://nhm.gov.in/nrhm-components/health-systems-strengthening/infrastructure.html>.

53. *ibid*.

deliveries; support for delivery at home; postnatal care (including a minimum of two home visits); care of new-born; and nutrition;

- Counselling regarding family planning including contraceptive and child spacing methods, availability of various contraceptive methods and appropriate referral for safe abortion services;
- Referral services including transport (by PHCs or by hired vehicles) with the Government covering all costs of transportation

Community Health Centers (CHC)

Community Health Centers (CHCs) are obligated to provide the full range of services under SHCs and PHCs, as well as essential and emergency obstetrics care; full range of family planning services; safe abortion services; good bank facility; essential laboratory services and a provision of implementation of all National Health Programmes. There is 1 CHC per 1,20,000 population in general areas and 1 per 80,000 population in areas with a difficult terrain.⁵⁴

Janani Suraksha Yojana (JSY)

JSY was launched in April 2005 by making modifications to the National Maternity Benefit Scheme (NMBS) with an objective to reduce maternal and neonatal mortality through promotion of institutional deliveries.⁵⁵

Unlike the NMBS, which provides financial assistance of Rs 500/- per birth up to two live births to all pregnant women aged 19 and belonging to below poverty line (BPL) households, JSY employs a graded scale of assistance based on categorization of States and whether the beneficiary resides in rural or urban areas. States classified as Low Performing States (LPS) have provisions for a higher amount of financial assistance as compared to High Performing States (HPS). States are classified based on the rate of institutional deliveries. LPS include Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Rajasthan, Odisha, Assam and Jammu & Kashmir.⁵⁶

Cash entitlements for different categories of women are as follows⁵⁷:

54. *ibid.*

55. "Janani Suraksha Yojana - Background". 2018. *Nhm.Gov.In*. <http://nhm.gov.in/nrhm-components/rmnc-h-a/maternal-health/janani-suraksha-yojana/background.html>.

56. *ibid.*

57. Press Information Bureau (Ministry of Health and Family Welfare, Government of India). 2015. "Janani Suraksha Yojna". <http://pib.nic.in/newsite/PrintRelease.aspx?relid=123992>.

Category	Rural Area		Urban Area	
	Mother's package	ASHA's package	Mother's package	ASHA's package
LPS	1400	600	1000	400
HPS	700	600	600	400

The ASHA package includes an ante natal checkup component and facilitating institutional delivery. Notably, women who chose to deliver at home are also entitled to Rs. 500/- per delivery, regardless of the age of the pregnant woman and the number of children she has.⁵⁸

JSY identifies ASHAs as the link between state and pregnant women living below poverty line. In cases where ASHAs are unavailable or inaccessible, Anganwadi workers and other similar activists may be engaged to take on provision of services under the scheme. ASHAs are responsible for identifying pregnant women from BPL families as beneficiaries under the scheme; reporting beneficiaries to ANMs and bringing them to SHCs/PHCs for registration; assisting them in obtaining necessary BPL card or certification if not already available; assisting women in receiving a minimum of three ante natal checkups, as mandated by the scheme; counselling when regarding their delivery plans and presenting the advantages of an institutional birth; assisting women in fixing their birth plans in close consultation with ANMs and PHCs; assisting women receive two TT injections; escorting women to their pre-determined health centre and staying with them until the delivery is complete and they have been discharged; registering birth or death of the child or mother; conducting post natal visits within 7 days of the delivery to keep a track of the mother's health; counselling and assisting mothers in breastfeeding within an hour of the delivery and until three to six months thereafter; and arranging immunization for the newborn baby till the age of 10 weeks.⁵⁹

The scheme is implemented through a Mission Steering Group at the national level and the State Health Mission at the state level. They are responsible for overseeing matters of monitoring and evaluation of the scheme. The number of beneficiaries under JSY has increased dramatically from 7.38 Lakhs beneficiaries in 2005-06 to 104.38 Lakhs in 2014-2015. Nevertheless, there are a huge number of cases reported where benefits are denied and women face immense struggle in accessing the funds that they are entitled to.

58. *ibid.*

59. Ministry of Health & Family Welfare, Government of India. 2018. "Janani Suraksha Yojana Guidelines For Implementation". New Delhi: Ministry of Health & Family Welfare. <http://www.ilo.org/dyn/travail/docs/683/JananiSurakshaYojanaGuidelines/MinistryofHealthandFamilyWelfare.pdf>

Janani Shishu Suraksha Karyakram (JSSK)

The Janani Shishu Suraksha Karyakram (JSSK) was launched on 1st June 2011 under the National Rural Health Mission (NRHM), in light of continued high numbers of maternal and infant mortality.⁶⁰ The scheme aimed to reduce the high out-of-pocket expenditure that pregnant women incurred in the form of cost of essential drugs, user charges in hospitals, diagnostic tests, diet, and C-section births.⁶¹

Hence, JSSK provides for entirely free and cashless treatment for pregnant women and infants needing medical attention. Free entitlements for the pregnant women include: free and cashless delivery (both natural births and C-sections); free drugs and other consumables; free diagnostic tests and consultations; free dietary meals during hospital stay (upto three days during normal delivery and seven days during C-section deliveries); exemption from user charges; free provision of blood wherever required; free transport to and from hospitals, as well as to any other health facility in case of a referral. Newborn babies suffering from sickness are afforded the same entitlements up until 30 days after the birth.⁶² Through provisions such as that of free transport and meals, the scheme also aims to encourage institutional deliveries.

Although JSSK has made the public health system more accessible to the community, there remain certain vulnerable groups of people who are denied access to benefits under the policy. For instance, an evaluation of the implementation of JSSK in the state of Chhattisgarh found that tribal areas did not always get the benefits that they were entitled to under the scheme.⁶³ 45 percent of women did not receive free food; free transport to a higher public facility was not always available; public health centers were frequently not equipped with essential medicines, blood banks, facilities necessary for C-sections or even a gynecologist. Moreover, 56 percent of women continued to incur out-of-pocket expenses.⁶⁴ A second study conducted in Himachal Pradesh found that only 63 percent of women received full benefits under JSSK and only 19 percent receive full transport benefits.⁶⁵ Hence,

60. "Janani Shishu Suraksha Karyakram - Background". 2018. *Nhm.Gov.In*. <http://nhm.gov.in/nrhmcopponents/reproductive-child-health/jssk.html>.

61. "Janani Shishu Suraksha Karyakram - Situation". 2018. *Nhm.Gov.In*. <http://nhm.gov.in/nrhmcopponents/reproductive-child-health/jssk.html>.

62. "Janani Shishu Suraksha Karyakram - The New Initiative". 2018. *Nhm.Gov.In*. <http://nhm.gov.in/nrhmcopponents/reproductive-child-health/jssk.html>.

63. Nandi, Sulakshana, Dipa Sinha, Deepika Joshi, Rajesh Dubey, and Vandana Prasad. 2016. "EVALUATION OF THE JANANI SHISHU SURAKSHA KARYAKRAM: FINDINGS ON INEQUITY IN ACCESS FROM CHHATTISGARH, INDIA". *BMJ Global Health* 1 (A4). http://gh.bmj.com/content/1/Suppl_1/A4.1.

64. *ibid*.

65. Kaur, Prabhdeep, Uvi Tyagi, and Kamaraj Pattabi. 2016. "Utilization Of Services Under Janani Shishu Suraksha Karyakram For Institutional Deliveries In The Public Sector Facilities, Sirmaur District, Himachal Pradesh, India". *Indian Journal Of Community Medicine* 41 (1): 65. doi:10.4103/0970-0218.170992.

implementation of JSSK remains a major area of concern with marginalised populations not receiving key entitlements of the scheme.

Pradhan Mantri Matru Vandana Yojana (PMMVY)

Announced in the Prime Minister's address on 31st December 2016, the Pradhan Mantri Matru Vandana Yojana (PMMVY) provides financial assistance to pregnant women and lactating mothers.

The conditionality and installments for the scheme are laid out in the table below⁶⁶:

Installment	Conditions	Documents Required	Amount (in Rs.)
First Installment	Requires mother to:- Register her pregnancy in the MCP (Mother Child Protection) card long with all required documents within 150 days from LMP.	Duly filled Application Form 1A Copy of MCP card Copy of Identity Proof Copy of Bank/Post Office Account Passbook	1,000
Second Installment	Requires mother to:- Undergo at least 1 antenatal checkup Claim installment amount within 180 days of the pregnancy	Duly filled Application Form 1B Copy of MCP Card	2,000
Third Installment	Requires:- Registration of child birth Child to have received the first cycle of immunizations of BCG, OPV, DPT and Hepatitis B or its equivalent substitute Mother to have an Aadhaar card (mandatory in all states except J&K, Assam and Meghalaya)	Duly filled Application Form 1C Copy of MCP Card Copy of Aadhaar ID Copy of Child Birth Registration Certificate	2,000

66. Ministry of Women and Child Development. 2018. "Training Module For PMMVY". New Delhi: Ministry of Women and Child Development, Government of India. http://www.wcd.nic.in/sites/default/files/Training%20Module_v4.4%20%2023102017.pdf

Ministry of Women and Child Development. 2017. "Pradhan Mantri Matru Vandana Yojana (PMMVY) - SCHEME IMPLEMENTATION GUIDELINES". New Delhi: Ministry of Women and Child Development, Government of India. <http://www.wcd.nic.in/sites/default/files/PMMVY%20Scheme%20Implementation%20Guidelines%20.0.pdf>

Hence, women are entitled to a total of Rs. 5,000/- for their first pregnancy under PMMVY. Eligible beneficiaries would receive benefits under JSY as well, allowing for a total financial assistance of Rs. 6000/-. Centrally sponsored, the scheme is implemented primarily through platforms of Anganwadi Services and ASHA/ANM workers.⁶⁷

Integrated Child Development Services Scheme (ICDS)

Launched in 1975, the ICDS scheme is considered a flagship programme of the Government of India.⁶⁸ It is targeted at children upto six years of age, pregnant women and lactating mothers. The objectives of the scheme are⁶⁹:

- To improve the nutritional and health status of children in the age group of 0 - 6 years;
- To lay the foundation for proper psychological, physical and social development of the child;
- To reduce the incidence of mortality, morbidity, malnutrition and school dropout;
- To achieve effective co-ordination of policy and implementation amongst the various departments to promote child development;
- 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

Hence, ICDS incorporates services such as provision of supplementary nutrition, nutrition and health education, immunization, health checkups, referral services and non-formal education for children before commencement of schooling.⁷⁰ The Scheme provides platforms through which these services may be delivered to the beneficiaries: Anganwadi Centers. Anganwadi Centers are community based child welfare centers which house Anganwadi Workers (AWWs) and Anganwadi Helpers. The Anganwadi Worker is a woman selected from the local community who acts as the frontline honorary worker of the ICDS Programme. She is also an agent of social change, mobilizing community support for better care of young children, girls and women.⁷¹ Apart from these, ASHA workers, Auxiliary Nurse Midwives (ANMs), Medical Officers, Child Development Project Officers (CDPOs) and District Programme Officers (DPOs) are focal points through which the benefits of the scheme can be delivered.⁷²

67. *ibid.*

68. Ministry of Women and Child Development. 2018. "INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) SCHEME". *Icds-Wcd.Nic.In*. <http://icds-wcd.nic.in/icds.aspx>.

69. *ibid.*

70. *ibid.*, Services Under ICDS.

71. *ibid.*, The ICDS Team.

72. *ibid.*

Private Sector

Increasingly, the private sector has taken advantage of gaps in public health care. It has been playing an increasingly dominant role in the country's healthcare structure. Families who can barely afford medical care opt to deliver in private facilities to avoid the substandard and undignified conditions in public facilities. Women collect their JSY payment regardless of whether the delivery takes place in a private or public facility. Under the Government's insurance scheme for BPL families, Rashtriya Swasthya Bima Yojana (RSBY), private facilities have been accused of performing unnecessary C-Sections and hysterectomies to reap substantial payments from the Government.

The United Nations Committee on Economic, Social, and Cultural Rights has lamented India's shift toward privatization: "The Committee is also concerned that the quality and the availability of the health services provided under the scheme have been adversely affected by the large-scale privatization of the health service in the State party, impacting in particular on the poorest sections of the population..."

International Law

India is a signatory to multiple international conventions which address a variety of human rights, including reproductive rights. Therefore, India has a duty to protect, promote and respect reproductive rights. Reproductive rights may fall under the following international conventions and treaties:

- Convention on the Elimination of Racial Discrimination (CERD), 1965
- International Covenant on Civil and Political Rights (ICCPR), 1966
- International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966
- Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), 1979
- United Nations Convention against Torture (CAT), 1987
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Rights of Persons with Disabilities (CRPWD), 2006

Right to life

Right to life means something more than mere animal existence and includes within its ambit all aspects of life which go to make a man's life meaningful and worth living.

Right to liberty and security of person

Arbitrary arrests and detention curtail the right to liberty of an individual. Thus, this right provides for security to an individual from arbitrary arrests and detention.

The right to health, including the right to sexual and reproductive health

The right to health is not restricted to be healthy but it contains freedoms and entitlements. This includes 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.

Right to freely decide number and spacing of children

This right encompasses the right to decide the number of children one can have and the time gap during which they are to be conceived. This is safeguard against State providing for maximum / minimum number of children along with the period they are to be born

The right to consent to marriage and equality on marriage

This right confers upon an individual right to freely give his consent to marriage and decide when he/she wishes to get married. This acts as a protection against other individuals (including parents) coercing others to get married. This also maintains that, in marriage, both partners are to be treated as equals

The Right to privacy

This right provides for exclusion of State from private matters of an individual.

The right to equality and non-discrimination

This right provides for equality of all persons irrespective of any other factors like gender, caste, creed, sex etc. Another aspect of this right entails non-discrimination so that equality can be fully enjoyed.

The right to be free from practices that harm women and girls

Various customs and social practices harm women on the basis of various prevalent prejudices and bias. This right provides protection against such customs and practices.

The right not to be subjected to torture or other cruel, inhuman, or degrading treatment or punishment

An individual should not be tortured or treated with cruelty which degrades human dignity or shall not be subjected to such inhuman acts. This extends to treatment met out during punishment.

The right to be free from sexual and gender-based violence

This right prevents sexual and gender-based violence like domestic violence. This is part of personal liberty of an individual so that an individual can have meaningful life worth living.

The right to access sexual and reproductive health education and family planning information

This right includes education on the various aspects of the genitals, healthy functioning of it, diseases associated with it. It also provides family planning advices such as number of children one a couple should have to have stable financial condition offering better growth and development of the entire family.

The right to enjoy the benefits of scientific progress

Science is the tool of development and everyone has a right to development. It becomes imperative for the State to make available the benefits of scientific progress to every individual for their development.

Access to Safe Abortion Services

India's Medical Termination of Pregnancy (MTP) Act of 1971 allows women to have an abortion up to the 20th week of pregnancy. Before 1971, India's law did not allow abortion at all. Even though this law and various government schemes guarantee access to *safe* abortion, fewer than 10% of Primary Health Centers (PHCs) provide abortion services and it reflects on the poor quality of health facilities available for the public. The recent study on abortion by The Lancet Global Health Medical Journal revealed quite a shocking picture. 1.56 Crore abortions have taken place in 2015 across India. About 81% of these are medication abortions, 14% are surgical and the remaining is through other methods which would include unsafe methods too.

Human Rights Law Network has taken a brave stand and has filed several petitions in the High Courts as well as the Supreme Court. In 2008, the Niketa Mehta Case set the precedent. For the first time, a case was filed on an issue which was not widely spoken of. Mentioned below are few of the cases as follows:

1. Nikhil Datar vs. Union of India (Civil Appeal - 7702/2014)

Synopsis

In 2008 for the first time, the case of Dr. Nikhil D. Datar and others v Union of India and others, popularly known as Haresh and Niketa Mehta case questioned the mothers' choice to abort during advanced stage of pregnancy, **(like, beyond 20 weeks in this case)**. This

case opened the gates to a number of cases of Abortion beyond the 20 weeks gestation period that were taken up in the Supreme Court. Few of such cases have discussed in this chapter.

Facts

In cases where the doctors could predict that there is a substantial risk if the child is born, like it would suffer from such physical or mental abnormality or can be seriously handicapped and tantamount, the women should be allowed to terminate the pregnancy. However, the MTP Act of 1971 had no provisions for that. Through the petition, the petitioners sought explanation and wanted to include such eventualities which would enable and thereby allow the petitioner to terminate her pregnancy. In 2008, The Mumbai High Court upheld the current Act. In 2014, HRLN filed this matter in the Supreme Court to ensure change.

Since Dr. Datar initially filed the petition, additional women have shared experiences of mental and physical anguish under the current MTP Act. For example, Mrs. Y, a woman in Bombay was forced to carry and deliver a non-viable fetus because the medical tests to determine the fetus' condition could only be administered after the 20th week. In light of stories like Mrs. Y's and medical developments, the National Women's Commission has also made a recommendation to increase the time limit in the MTP Act. HRLN has filed these developments on the issue and our advocates are still pushing for a final hearing on the matter to get justice for individual victims and to ensure legal reform. The Ministry of Health and Family Welfare has also put forward amendments to the Medical Termination of Pregnancy Act including extending the number of weeks when women can legally obtain abortion services.

Order

Bombay HC stated that no case was made out for the reliefs asked for thereby dismissing the petition. On 15.04.2009 the petitioners appealed in the Apex Court to challenge the High Court's decision. In 2014 the case was taken to the Supreme Court. On 15.12.2016 the Supreme Court directed the learned counsel appearing for the Union of India to take instructions and file an affidavit on what the Union of India proposes to do in the matter.

2. Amita Kujur vs. State of Chhattisgarh & Ors. Writ Petition (Civil) No. 976/ 2016

Synopsis

In the above mentioned case the petitioner was a rape survivor in Bilaspur, Chhattisgarh who had sought relief to terminate her pregnancy beyond the 20 week gestation period as described under Section 3 of the Medical Termination of Pregnancy Act, 1971.

Facts

The petitioner is a rape survivor. She had lodged an FIR in P.S. Bagicha, District Jashpur in Chhattisgarh on 21.03.2016 that she was subjected to rape between the periods from 07.03.2015 to 13.03.2016. In view of facts disclosed, report was sent to P.S. Kansabel, District Jashpur. It is stated in the petition that P.S. Kansabel had registered an offence against the accused alleging commission of offence under Section 376 IPC. The petitioner was subjected to Medical Legal Examination by Government Doctor in a Government Hospital at Jashpur.

The petitioner had stated on affidavit in the petition that despite repeated representation and requests made, she had not been taken to the hospital at Bilaspur for termination of pregnancy, despite willingness, as per the provision contained in Section 3 of the Medical Termination of Pregnancy Act, 1971 (for short “the Act of 1971”).

Learned counsel for the petitioner submitted that as in the Government Hospital at Jashpur, pregnancy could not be terminated due to the lack of expert doctors, request was made to the Station House Officer to take the petitioner to Chhattisgarh Institute of Medical Sciences at Bilaspur where experts were available but she was advised to proceed on her own. The petitioner contacted the doctors in Gynecology Department of Chhattisgarh Institute of Medical Sciences at Bilaspur on 12.04.2016 but the doctors expressed their inability on the ground that unless copy of FIR, MLC report and referral order of Jashpur Government Hospital presented, no further steps could be taken.

It was also submitted that according to the MLC report prepared by Government doctor at Jashpur, the period of 20 weeks, beyond which ordinarily the Act does not permit termination of pregnancy was expiring in couple of days. Therefore, a prayer had been made for emergent orders in the matter otherwise serious complications might occur.

In view of the above, a direction was issued to the Rekha Deen Chhattisgarh Institute of Medical Sciences Bilaspur to constitute immediately team of two doctors to perform medical examination of the petitioner form an opinion in terms of the provision contained in Section 3 of the Act of 1971 and take suitable steps on the basis of such an opinion in the matter of termination of pregnancy.

Learned Deputy Advocate General should directly inform the Dean- Chhattisgarh Institute of Medical Sciences Bilaspur through the Collector of the District today itself and on submission of copy of FIR before the Dean, the team of doctors proceeded to medically examine the petitioner and such examination shall not be denied on the ground of non-production of referral letter or MLC.

Relevant Laws

Constitution: Article 21 (Right to a dignified life)

Statutes & Schemes: Medical termination of Pregnancy Act, 1971

International Law: K.I. v. Peru, Communication No 1153/2003, Human Rights Committee, U.N. Doc. CCPR/C/85/D/1153/2003 (2005). Finding that women have the right to safe legal abortions in the case of foetal abnormality, and the denial of the same violates women's right to be free from cruel, inhuman and degrading treatment.)

Order

20th April, 2018

1. This petition has been filed by the petitioner, victim of a rape, for a direction to facilitate termination of her pregnancy, which according to her, is the result of commission of offence of rape on her.
2. On a petition filed before this Court by the petitioner, this Court directed medical examination of the petitioner to find out the gestational age. Pursuant to the direction issued by this Court on 13.4.2016, the petitioner was medically examined by a team of doctors. The case was directed to be listed on 18.4.2016.

On 18.4.2016, learned counsel for the State made statement before this Court that the petitioner has been examined by a team of doctors. On this disclosure made, the report was directed to be filed on 18.4.2016 itself and the case was directed to be listed today. That is how the matter has come up for consideration before this Court.

3. Learned counsel for the petitioner argues that the petitioner is a tribal girl from Jashpur district who was abducted and taken to Alwar district of Rajasthan, where she was subjected to rape. After she was recovered, an FIR was lodged in Police Station -Bagicha on 21.3.2016, which was transferred to jurisdictional Police Station- Kansabel. A copy of the report has been placed on record as Annexure P-1. The petitioner having come to know that she had conceived as a result of rape, she represented to the Collector, Jashpur on 28.3.2016 to facilitate termination of her unwanted pregnancy. A representation was also made to the Superintendent of Police, Jashpur on 28.3.2016 itself. Those representations have been placed on record as Annexure P-2 collectively.

According to the pleadings, on 28.3.2016 itself, Additional Superintendent of Police & In charge, Anti Human Trafficking Cell, assured immediate follow-up action and it is said that he telephonically instructed the police officers of Police Station- Kansabel to take necessary steps. It is the allegation of the petitioner that despite all steps taken by her informing the State and Police Authorities to facilitate termination of pregnancy and an approach made to Chief Medical and Health Officer, Jashpur, steps were not taken and she was advised to approach Chhattisgarh Institute of Medical Science (CIMS) Bilaspur. When she approached doctors at CIMS, she was informed that she needs to bring the copy of FIR, MLC report and a referral letter from District Hospital, Jashpur. As the State Authority and Police Authority did not facilitate termination of pregnancy, though strongly desired by the petitioner, to prevent herself from severe mental agony of carrying unwanted pregnancy, the petitioner has now knocked the doors of justice by filing this petition.

4. Relying upon the judgment of the Supreme Court in the case of Chandrakant Jayantilal Suthar & Anr. Vs. State of Gujarat¹, Suchita Srivastava & Anr. Vs. Chandigarh Administration² and order dated 19.2.2016 passed by the High Court of Gujarat in the case of Bhavikaben D/o. Rameshbhai Solanki Vs. State of Gujarat & Ors.³, prayer has been made to direct termination of pregnancy applying best interest theory and to prevent the petitioner from further mental agony which is a grave injury to the petitioner. Learned counsel for the petitioner has prayed for issuance of immediate direction in that regard.

5. Learned counsel for the respondents-State submits that as per the direction of this Court, the petitioner was examined on 13.4.2016 by a team of doctors and report has been placed on record.

6. As per the medical examination report dated 13.4.2016 given by a team of two doctors, following opinion has been formed:

“Opinion: According to last menstrual period her gestational age is 20 weeks 4 days with P/A

finding of pregnant uterus size 20-22 weeks and as per USG her mean gestational age is 20 weeks 4 days (copy enclosed). Hence according to MTP Act 1971 section 3 sub-section 2 b (copy enclosed), her pregnancy has exceeded the legal limit for MTP i.e. 20 weeks, therefore further direction is anticipated by the Hon'ble High Court, Chhattisgarh for further proceedings”

From the report, it is found that on 13.4.2016, the petitioner was found carrying pregnancy of more than 20 weeks.

7. At this stage, it is relevant to refer to the legal framework and the law of the land regulating the Medical Termination of Pregnancy Act, 1971 (hereinafter referred to as “the Act of 1971”). The circumstance under which pregnancy may be terminated by registered medical practitioners has been provided under Section 3 of the aforesaid Act, which reads as follows:

“3. When pregnancies may be terminated by registered medical practitioners.—(1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner,—(a) where the length of the pregnancy does not exceed twelve weeks, if such medical practitioner is, or (b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are, of opinion, formed in good faith, that— (i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or (ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. Explanation I.—where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman. Explanation II.—where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

(3) In determining whether the continuance of pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

(4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a [mentally ill person], shall be terminated except with the consent in writing of her guardian. (b) Save as otherwise provided in clause (a), no pregnancy shall be terminated except with the consent of the pregnant woman.”

The provision, as it reads, allows termination of pregnancy upon formation of opinion in good-faith with regard to circumstances specified in clause (i) & clause (ii) of sub-section (2) of Section 3 of the Act of 1971, quoted herein -above.

“Explanation -I provides in no uncertain terms that where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.”

8. The petitioner, a victim of rape, has clearly expressed her strong desire to avoid giving birth to child which is a result of rape on her. It has been stated in her pleadings in additional memorandum filed on 18.4.2016 that the petitioner has studied only up to Class-XII and did not go to college because of financial reason. Her mother passed away when she was young, her father is old and infirm. Presently she is financially dependent on her brothers who are married. Thereafter, what has been stated by the petitioner requires special mention and reproduction also as herein-below:

“The petitioner is under a lot of mental pressure and cannot bear stigma of being an unwed mother, she does not want to give birth to a child.

9. The situation which now stands as on today is that though the petitioner is not at all willing to carry pregnancy and seeks termination of her pregnancy so as to put an end to at least an agony of giving birth to an unwanted child, but the period of 20 weeks as provided in the Act has already elapsed. In fact, when the matter came up for consideration before this Court for the first time, the gestational period had crossed 20 weeks. As on today, the period of pregnancy is little more than 21 weeks.

10. The course of action which is required to be taken has to be guided by the principles of best interest theory laid down by the Supreme Court in the case of Suchita Srivastava (supra). In the aforesaid decision, the Supreme Court evolved the test and held that the Court is required to ascertain the course of action which would serve the best interests of the person in question. It has also emphasized that the Court must undertake a careful inquiry of the medical opinion on the feasibility of pregnancy as well as social circumstances faced by the victim. The Court’s decision should be guided by the interests

of the victim alone and not those of stakeholders such as guardians or society in general. The observation made by the Supreme Court in para-37 of the judgment need attention, which reads thus:

“37. As evident from its literal description, the “best interests” test requires the Court to ascertain the course of action which would serve the best interests of the person in question. In the present setting this means that the Court must undertake a careful inquiry of the medical opinion on the feasibility of the pregnancy as well as social circumstances faced by the victim. It is important to note that the Court’s decision should be guided by the interests of the victim alone and not those of the other stakeholders such as guardians or the society in general. It is evident that the woman in question will need care and assistance which will in turn entail some costs. However, that cannot be a ground for denying the exercise of reproductive rights.

11. A somewhat similar situation arose for consideration before the High Court of Gujarat in the case of Bhavikaben (supra). There the gestational age was of 24 weeks. That was also a case of rape victim. She tried to put an end to her life by consuming acid. She was ailing from medical problem also. Applying the best interest theory propounded by the Supreme Court in the case of Suchita Srivastava (supra) and the direction issued by the Supreme Court in another case of Chandrakant Jayantilal Suthar (supra), directions were issued for termination of medical pregnancy under supervision and care of doctors.

12. In the present case, the pregnancy has crossed 21 weeks of gestational age and unless there is judicial order as has been expressed in the opinion, it may not be possible for the doctors even to proceed with termination of pregnancy.

13. Taking into consideration the totality of the circumstances what has been stated by the victim, gestational age, judicial precedents, that as per Explanation –I appended to Section 3 of the Act of 1971 mental agony of a rape victim has to be treated as a case of grave injury, particularly taking into consideration that it is the interests of the victim alone which has to be kept in view, this Court is inclined to direct the treating doctors to terminate the pregnancy. Taking into consideration that period of 21 weeks has elapsed, in order to ensure the safety of life of the petitioner, it would be proper to direct that the team of five doctors including those who have already conducted medical examination shall consider the feasibility of termination of pregnancy at this gestational age. In view of the order of the Supreme Court in the case of Chandrakant (supra), it has to be left to the best opinion and judgment of medical experts in the matter. Once they find that at this stage, pregnancy can be terminated looking to the

gestational age and overall condition of the petitioner, the same shall be carried out forthwith.

14. A copy of this order shall be supplied to learned counsel for the petitioner and Shri Ramakant Mishra, Dy.A.G., today itself, for immediate onwards transmission to Dean, CIMS, Bilaspur for forthwith and immediate examination as per opinion, termination of pregnancy also.

15. This case is kept pending for the purposes of verifying the well-being of the petitioner after termination of pregnancy or for any other order which may be required to be passed in the matter including appropriate direction to be issued to the State Authority to avoid present situation.

16. The Hospital Authority shall take necessary tissues from fetus for DNA identification.

17. Respondent-State shall submit a report with regard to compliance of the Court direction on the next date of hearing.

Outcome

The petitioner contacted the doctors in Gynecology Department of Chhattisgarh Institute of Medical Sciences at Bilaspur on 12.04.2016 but the doctors expressed their inability on the ground that unless copy of FIR, MLC report and referral order of Jashpur Government Hospital presented, no further steps can be taken.

Taking into consideration that the petition came to be filed by the petitioner in the Court because of delay in termination of pregnancy, the court directed to issue appropriate guidelines required in the matter.

The court further directed the counsel for the State to come out with suitable proposal in the matter in order to ensure that the concerned police and medical authorities are enjoined with duty to deal with such matters expeditiously, without delay.

3. Mrs. X & Ors vs. Union of India & Ors Writ Petition (Civil) No. 81 of 2017

Synopsis

The petitioner in this case had sought relief to terminate her pregnancy beyond the 20 week gestation period as described under Section 3 of the Medical Termination of Pregnancy Act, 1971 because of the fetal anomaly she had.

Facts

The Petitioner No. 1, Mrs. X was about 22 years' old. According to her, fetus which is about 22 weeks old on the date of the petition has a condition known as bilateral renal agenesis and anhydramnios. She apprehended that the fetus has no chance of survival and the delivery may endanger her life. The Medical Board had opined that the condition of the fetus was incompatible with extra-uterine life, i.e. outside the womb because prolonged absence of amniotic fluid results in pulmonary hypoplasia leading to severe respiratory insufficiency at birth. From the point of view of the petitioner the report had observed risk to the mother since continuation of pregnancy can endanger her physical and mental health.

Therefore, she had approached this Court under Article 32 of the Constitution of India seeking directions to the respondents to allow her to undergo medical termination of her pregnancy.

Relevant Laws

Constitution: Article 21 (right to a dignified life)

Statuses & Schemes: Medical termination of Pregnancy Act, 1971

International Law: K.L. v. Peru, Communication No 1153/2003, Human Rights Committee, U.N. Doc. CCPR/C/85/D/1153/2003 (2005). Finding that women have the right to safe legal abortions in the case of foetal abnormality, and the denial of the same violates women's right to be free from cruel, inhuman and degrading treatment.)

Order: Supreme Court of India

3rd February, 2017

Application for non-disclosure of names and detail of petitioner No. 1 and 2 is allowed.

The Petitioner No. 1- Mrs. X is about 22 years' old. She has approached this Court under Article 32 of the Constitution of India seeking directions to the respondents to allow her to undergo medical termination of her pregnancy. According to her, fetus which is about 22 weeks old on the date of the petition has a condition known as bilateral renal agenesis and anhydramnios. She apprehends that the fetus has no chance of survival and the delivery may endanger her life.

In order to verify the condition of petitioner No. 1, the Court by order dated 03.02.2017

while issuing notice to the respondents directed examination of the petitioner by a medical Board consisting of following seven Doctors:

1. Dr. Avinash N. Supe, Director (Medical Education & Major Hospitals) & Dean (G&K) – Chairman
2. Dr. Shubhangi Parkar, Professor and HOD, Psychiatry, KEM Hospital
3. Dr. Amar Pazare, professor and HOD, Medicine, KEM Hospital
4. Dr. Indrani Hemantkumar Chincholi, Professor and HOD, Anesthesia, KEM Hospital
5. Dr. Y.S. Nandanwar, Professor and HOD, Obstetrics, KEM Hospitals
6. Dr. Anahita Chauhan, Professor and Unit Head, Obstetrics & Gynecology, LTMMC and LTMG Hospitals
7. Dr. Hemangini Thakkar, Addl. Professor, Radiology, KEM Hospital.

By its report dated 04.02.2017, the Medical Board as constituted by this Court has given its expert opinion upon reviewing the complete history as narrated by the petitioner No. 1 and her brother along with all the papers. The petitioner No. 1 was examined by all the Board Members with specific recourse to the specialty.

The learned Solicitor General who appears on behalf of Union of India had the report evaluated by Doctor Veena Dhawan from the Ministry of Health. The said Doctor does not disagree with the findings by the Medical Board and is also in agreement with the proposed action by the Medical Board.

The salient features of the report are:

“.. Ultrasonography diagnosis is single live fetus with gestational age of 24 weeks 3 days with bilateral renal agenesis with double outlet right ventricle with ventricular septal defect with two vessel cord with anhydramnios.... Opinion of Pediatric Surgeon in charge of Birth Defect Clinic : There is risk of intrauterine fetal death/ still birth and there is no chance of long term post natal survival, and no curative treatment is available at present for bilateral renal agenesis. There is thus a clear diagnosis of the condition of the single live fetus which is said to have bilateral renal agenesis which means the fetus has no kidneys and anhydramnios which means that there is an absence of amniotic fluid in the womb. Further, there is a clear observation that there is a risk of intrauterine fetal death, i.e. death within womb and there is no chance of a long term post natal survival. What is important is that there is no curative treatment available at present for bilateral renal agenesis.

The Medical Board has opined that the condition of the fetus is incompatible with extra-uterine life, i.e. outside the womb because prolonged absence of amniotic fluid results in pulmonary hypoplasia leading to severe respiratory insufficiency at birth. From the point of view of the petitioner the report has observed risk to the mother since continuation of pregnancy can endanger her physical and mental health.

We have already vide order dated 16.01.2017 upheld the right of a mother to preserve her life in view of foreseeable danger in case the pregnancy is allowed to run its full course. This Court in that case relied upon the case of *Suchita Srivastava and Anr. vs. Chandigarh Administration* [(2009) 9 SCC 1], where a bench of three Judges held “a woman’s right to make reproductive choices is also a dimension of ‘personal liberty’ as understood under Article 21 of the Constitution”. In these circumstances we find that the right of bodily integrity calls for a permission to allow her to terminate her pregnancy.

The report of the Medical Board clearly warrants the inference that the continuance of the pregnancy involves the risk to the life of the petitioner and a possible grave injury to her physical or mental health as required by Section 3 (2)(i) of the Medical Termination of Pregnancy Act, 1971. It may be noted that Section 5 of the Act enables termination of pregnancy where an opinion is formed by not less than two medical practitioners in a case where opinion is for the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

Though the current pregnancy of the petitioner is about 24th weeks and endanger to the life and inevitable to the death of the fetus outside womb, we consider it appropriate to permit the petitioner to undergo termination of her pregnancy under the provisions of the Medical Termination of Pregnancy Act, 1971. We order accordingly.

The termination of pregnancy of petitioner no.1 will be performed by the Doctors of the hospital where she has undergone medical check-up. Further, termination of her pregnancy would be supervised by the above stated Medical Board who shall maintain complete record of the procedure which is to be performed on petitioner No.1 for termination of her pregnancy.

Shri Ranjit Kumar, learned solicitor General rightly points out that the affidavit in the present case is not sworn by petitioner No. 1 who seeks termination of her pregnancy and is sworn by a Doctor who is petitioner No.3. We might note that a relator action may not be permitted in a case of this kind. There would be various circumstances about which the Court must be assured of before the order is made. Conceivably, in a given case petitioner

No. 1 may be under some misconception or under coercion. We do not find that to be case here because Petitioner No. 1 has been examined by the Medical Board about her mental condition. In fact the Board has made a psychiatric evaluation of her and has stated that the patient is co-operative and coherent and has no psychiatric or emotional problems. Hence we do not propose to deny relief to petitioner No. 1. It is however, made clear that such action must be supported by affidavits of the petitioner No. 1 herself. Needless to state that KEM Hospital will take her consent before terminating her pregnancy.

With the aforesaid directions, the instant writ petition is allowed in terms of prayer (a) seeking direction to the respondents to allow petitioner no.1 to undergo medical termination of her pregnancy.

Application for non-disclosure of names and details of petitioner No. 1 and 2 is allowed.

With the directions contained in the signed order writ petition is allowed in terms of prayer (a) seeking direction to the respondents to allow petitioner No. 1 to undergo medical termination of her pregnancy.

Outcome

As the current pregnancy of the petitioner is about 24 weeks and there is an inevitable threat to the life of the fetus outside womb, the Court considered it appropriate to permit the petitioner to undergo termination of her pregnancy under the provisions of the Medical Termination of Pregnancy Act, 1971. Continuing the pregnancy could've put the mother's physical health at risk. Moreover, the child born wasn't compatible enough with the extra-uterus life (outside the uterus); leading to its minimum scope of survival. Therefore, in the interest of everyone, the best option was to terminate the pregnancy.

4. Sarmishtha Chakraborty & Anr. Vs. Union of India Secretary & Ors. Writ Petition (Civil) No. 431 of 2017

Facts

This petition challenges the validity of section 3 (2) (b) of the Medical Termination of Pregnancy Act, 1971 (MTP) restricted to the ceiling of 20 weeks, for the termination of pregnancy, stipulated therein. It was detected, only after 20 weeks of the pregnancy, that the fetus suffered from a combination of four impairments in the heart (Tetralogy of Fallot). However, as the Petitioner No.1, Sarmishtha Chakraborty had crossed the 20 weeks mark,

she wasn't allowed to terminate the pregnancy; and had to continue her pregnancy knowing the fact that the fetus may not survive. The present writ petition is being filed under Article 32 of the Constitution of India seeking relief for the Petitioner no. 1 who has suffered immense physical and mental anguish.

Relevant Laws

Constitution: Article 21 (right to a dignified life)

Statuses & Schemes: Medical termination of Pregnancy Act, 1971

International Law: K.I. v. Peru, Communication No 1153/2003, Human Rights Committee, U.N. Doc. CCPR/C/85/D/1153/2003 (2005). Finding that women have the right to safe legal abortions in the case of foetal abnormality, and the denial of the same violates women's right to be free from cruel, inhuman and degrading treatment.)

Order: Supreme Court of India

23rd June, 2017

The petitioners, the husband and wife, have moved this petition under Article 32 of the Constitution with manifold prayers. In the course of hearing, Mr. Colin Gonsalves, learned senior counsel appearing for the petitioners, has restricted his argument to prayer (g) which pertains to issue of direction for constituting a medical board to assess the pregnancy of the 1st petitioner and direct for termination of the pregnancy.

When the matter was listed on 21.6.2017, the Court took note of the prayer for appointment of a panel of doctors at a Government hospital in Kolkata to examine the state of health of the mother and accordingly directed the matter to be listed on 23.6.2017.

When the matter was listed on 23.6.2017, this Court had passed the following order :-

In pursuance of the previous order of this Court "dated 21.06.2017, learned standing counsel appearing on behalf of the State of West Bengal has placed on the record his instructions indicating that a team of senior Doctors may be constituted to evaluate the mental and physical health of the first petitioner and the state of health of the foetus. At this stage, the pregnancy is in its 25th week.

The court has been appraised of the medical reports produced on record by the petitioners, including the opinion of Doctor Devi Shetty, which is annexed to the paper book. We accordingly constitute a Medical Board consisting of the following Doctors to examine

the first petitioner and her foetus at the Institute of Post Graduate Medical Education & Research (SSKM Hospital) situated at 244 A.J.C. Bose Road, Kolkata -700 020: (NAME HOSPITAL ATTACHED)

Prof.(Dr.) Arati Biswas National Medical College & Hospital

Prof (Dr.) Suchandra Mukherjee I.P.G.M.E.R. (SSKM Hospital)

Prof (Dr.) Utpal Das I.P.G.M.E.R. (SSKM Hospital)

Prof (Dr.) Subhas Chandra Biswas I.P.G.M.E.R. (SSKM Hospital)

Prof (Dr.) Acchyut Sarkar I.P.G.M.E.R. (SSKM Hospital)

Prof (Dr.) Sujitesh Saha I.P.G.M.E.R. (SSKM Hospital)

Prof (Dr.) Santanu Datta I.P.G.M.E.R. (SSKM Hospital)

We request the Medical Board to examine the first petitioner and to submit its evaluation report of the first petitioner and the foetus to this court on 29.06.2017 in a sealed cover. A copy shall also be furnished to the Standing counsel for the State of West Bengal in sealed cover. List on 29th June, 2017.”

In pursuance of the aforesaid order, a Medical Board was constituted and a report was submitted before this Court on 29.6.2017. Thereafter, the matter was directed to be listed today.

It is submitted by Mr. Colin Gonsalves, learned senior counsel appearing for the petitioners that the medical report clearly stipulates the condition of the 1st petitioner and if the report is appositely appreciated, the direction, as prayed for, deserves to be granted. We think it appropriate to reproduce the observations and opinion of various members of the Medical Board. The report of the Medical Board reads as under:

“ Observation of Dr. Utpalendu Das, Professor & H.O.D. of Radiology, IPGMER-SSKM Hospital, Kolkata- As per the available medical records including anomaly scan dated 25/05/2017 at gestational age of 20 weeks 5 days reveals single life intrauterine fetus with normal fetal anatomy and grown except cardiac anomaly with suggestion of Tetralogy of Fallot: Fetal Echocardiography done on 6th June, 2017 reveals - Tetralogy of Fallot Large perimembranous VSD with inlet extension (bidirectional flow), Aorta from LV overriding the VSD, Pulmonary atresia, Duct/MAPCA dependent pulmonary circulation, Good Veticular Function

Opinion of Dr. Saroj Mondal, Asst. Professor of the Department of Cardiology, IPGMER-SSKM Hospital, Kolkata regarding continuation of pregnancy of Mrs. Sarmistha

Chakraborty, who is carrying 20 weeks 5 days as on 25.05.2017 of pregnancy with normal fetal growth having fetal cardiac malformation detected by fetal echo cardiography on 6th June, 2017 in the form of Tetralogy of Fallot, Large perimembranous VSD with inlet extension (bidirectional flow), Aorta from LV overriding the VSD, Pulmonary atresia, Duct/MAPCA dependent pulmonary circulation, Good Veticular Function. As the fetus has complex cardiac anomaly and if pregnancy continued mother will need delivery in a highly equipped centre with facility of neonatal cardiac intervention and surgical facility and will need multiple staged cardiac surgical operation and each occasion, it will have high morbidity and mortality risk. This case, I already discussed with Dr. Acchyut Sarkar, Associate Professor of the Department of

Cardiology, IPGMER-SSKM Hospital, Kolkata who is appointed as Pediatric Cardiologist of this Medical Board.

Impression of Dr. Santanu Dutta, Associate Professor of the Department of C.T.V.S., IPGMER-SS KM Hospital, Kolkata – As per the medical reports available, the fetal echocardiography shows Fetal complex congenital cyanotic heart disease.

Impression: Pulmonary Artesia with Hypoplastic PAS, large VSD and collaterals arising from aorta. It is evident from the report tha the neonate needs complex cardiac corrective surgery stage by stage after birth. But there is high mortality at every step of this type of staged surgeries.

Opinion of Dr. Sujitesh Saha, Associate Professor of the Department of Paed. Surgery, IPGMER-SSKM Hospital, Kolkata. As per the medical reports and fetal echo cardiogram done on 6th June, 2017, the fetus is having tetralogy of Fallot, Pulmonary atresia and large VSD, Multiple Collaterals arising from aorta to support the pulmonary circulation. As per records, there is no other fetal congenital malformation detected. On examination fetal growth parameters are normal. After birth multiple staged cardiac corrective surgery will be required which will be associated with high mortality and morbidity at every stage.

Opinion of Dr. Suchandra Mukherjee, Professor & HOD of Neonatology, IPGMER-SSKM Hospital, Kolkata- Pet the fetal echo-cardiography report dated 6th June, 2017, the fetus s having tetralogy of Fallot. Pulmonary atresia and large VSD, Multiple Collaterals arising from aorta to support the pulmonary circulation. No other fetal congenital malformation was demonstrated in the anomalies scan done at 20 weeks of gestation on 25th May 2017 and fetal growth parameter was found to be normal.

In view of the cardiac malformation, the baby, after birth will require intensive cardiac

monitoring and staged management through the surgical procedures which will have high risk of morbidity and mortality depending upon their postnatal course. Finally in pursuance of the Notice of the Director, IPGMER, Kolkata vide Memo N. Inst./5445 dated 23rd June, 2017, a medical board has been convened at 10.00 am on 27th June, 2017 in the Office Chamber of Dr. S.C. Biswas, Professor of the Department of Gynae & Obst, IPGMER-SSKM Hospital, in presence of all members of the constituted Medical Board by the Hon'ble Supreme Court, India. However, Associate Professor Dr. Acchyut Sarkar, Department of Cardiology was absent. He deputed Dr. Saroj Mondal, instead of him to express the view of Pediatric Cardiologist, IPGMER-SSKM Hospital, Kolkata

The patient, 1st Petitioner of the case Mrs. Sarmistha Chakraborty, 33 years old, w/o Mr.

Anirban Chakraborty was examined by the Board Members and all the members expressed their views. Two Gynaecologists, (1) Professor Subhash Chandra Biswas & (2) Professor Arati Biswas, on good faith examined the patient physically and observed the following findings:

Her L.M.P.-27.12.2016, E.D.D.-4.10.2017 & she is G2Po+1+0+0. Previous pregnancy- she had sudden bleeding P/V & pain abdomen at approximately seven and half months and delivered in Apollo Hospital, Kolkata, a still born baby vaginally (as per previous records) in 2015. On examination- She is conscious and co-operative with profound mental agony. Her Vitals-stable Per abdominal examination reveals

1. Fundal height of gravid uterus- 24 weeks+ (approx 26 weeks) (Corresponding to period of amenorrhoea)
2. Liquor-adequate (as per period of gestation)
3. Fetal parts-Palpable
4. F.H.S.+ & Regular

Patient, herself spontaneously expressed her wish not to continue this pregnancy in view of the detected fetal cardiac anomalies so far. On reviewing of the available records of the patient i.e. U.S.G., Fetal Echo-Cardiography including the prescription of the attending Obstetrician in Apollo Hospital, Kolkata, the other members of the Board (Radiologist, Cardiologist, Neonatologist, Pediatric Surgeon and Cardiac Surgeon) have opined that "the fetus has been detected to have cardiac malformation in the form of Tetralogy of Fallot, Large perimembranous VSD with inlet extension (bidirectional flow), Aorta from LV overriding the VSD, Pulmonary Atresia, Duct / MAPCA dependent pulmonary

circulation and Good Ventricular function. The child, if born alive, need complex cardiac corrective surgery stage by stage after birth. But there is high mortality and morbidity at every step of this staged surgeries”. The cardiac anomaly has been confirmed by serial investigations.

In view of the above facts and opinion, we, the two Gynaecologists, in good faith like to opine that the patient is at the threat of severe mental injury, if the pregnancy is continued. Therefore, if the patient wants termination of this pregnancy, she may be allowed with prior informed consent of inherent risk of her health for procedural inventions, because there is additional risk of termination of the pregnancy once it is beyond 20 weeks as the present case is. However, this is a special case and conclusion has been drawn on its individual merits.”

On a perusal of the aforesaid report, it is clear as crystal that the Medical Board is of the view that it is a case for termination of pregnancy, as a special case. As the last paragraph would show, the Board has mentioned that the patient is at the threat of severe mental injury, if the pregnancy is continued. It has also opined that the child, if born alive, needs complex cardiac corrective surgery stage by stage after birth. But there is high mortality and morbidity at every step of this staged surgeries.

Mr. Gonsalves, learned senior counsel has drawn our attention to two orders, one passed in *Meera Santosh Pal & Ors. vs. Union of India & Ors.* [WP (C) No. 17 of 2017 decided on 16.1.2017], wherein this Court, after considering the report of the Medical Board, has held thus :-

“Upon evaluation of petitioner no.1, the aforesaid Medical Board has concluded that her current pregnancy is of about 24 weeks. The condition of the fetus is not compatible with extra-uterine life. In other words, the fetus would not be able to survive outside the uterus. Importantly, it is reported that the continuation of pregnancy can gravely endanger the physical and mental health of petitioner no.1 and the risk of her termination of pregnancy is within acceptable limits with institutional back up.”

Learned senior counsel has also drawn our attention to another order passed in *Mrs. X & Ors. vs. Union of India & Ors.* [WP (C) No.81 of 2017 decided on 7.3.2017] wherein this Court had allowed the termination of pregnancy. The Court had taken the Medical report into consideration which was to the following effect: “There is thus a clear diagnosis of the condition of the single live fetus which is said to have bilateral renal agenesis which means the fetus has no kidneys and anhydramnios which means that there is an absence of amniotic fluid in the womb. Further, there is a clear observation that there is a risk of intrauterine fetal death, i.e. death within womb and there is no chance of a long term post

natal survival. What is important is that there is no curative treatment available at present for bilateral renal agenesis. The Medical Board has opined that the condition of the fetus is incompatible with extra-uterine life, i.e. outside the womb because prolonged absence of amniotic fluid results in pulmonary hypoplasia leading to severe respiratory insufficiency at birth.

From the point of view of the petitioner the report has observed risk to the mother since continuation of pregnancy can endanger her physical and mental health.

Mr. A.K. Panda, learned senior counsel appearing for the Union of India has drawn our attention to two other orders, one passed in *Savita Sachin Patil & Ors. vs. Union of India and Ors.* [WP (C) No.121 of 2017 decided on 28.02.2017] and another in *Sheetal Shankar Salvi & Anr. vs. Union of India & Ors.* [W.P. No.174 of 2017 decided on 27.3.2017]. In the case of *Savita Sachin Patil*, the Court declined to grant permission by holding, thus: “As regards the prognosis, the said medical report clearly does not and possibly cannot, observe that this particular fetus will have severe mental and physical challenges. It states that the *“baby is likely to have mental and physical challenges.”*”

In the earlier part of the said medical report, there is no observation made by the aforesaid Medical Board that every baby with Down Syndrome has low intelligence, but it was observed that *“intelligence among people with Down Syndrome is variable and a large proportion may have an intelligence Quotient of less than 50 (severe mental retardation)”*. In any case, it is not possible to discern the danger to the life of petitioner no.1 in case she is not allowed to terminate her pregnancy.

In the facts and circumstances of the case, it is not possible for us to grant permission to petitioner no.1 to terminate the life of the fetus.

In view of the above, as it presently advised, we decline the prayer (a) of the petitioners for directing the respondents to allow Petitioner No.1 to undergo medical termination of the pregnancy.”

In *Sheetal Shankar Salvi*, after perusing the report, the Court observed that there is no danger to mother’s life and the likelihood that the baby may be born alive and survive for variable period of time, and, therefore, it would not be appropriate to allow the petitioner No.1 to undergo medical termination of her pregnancy.

The orders which have been referred to by Mr. Panda, in our considered opinion, rest on their own facts. Frankly speaking, cases of this nature have to rest on their own facts because it shall depend upon the nature of the report of the Medical Board and also the

requisite consent as engrafted under the Medical Termination of Pregnancy Act, 1971. In the instant case, as the report of the Medical Board, which we have produced, in entirety, clearly reveals that the mother shall suffer mental injury if the pregnancy is continued and there will be multiple problems if the child is born alive. That apart, the Medical Board has categorically arrived at a conclusion that in a special case of this nature, the pregnancy should be allowed to be terminated after 20 weeks.

In the case of *Suchita Srivastava & Anr. vs. Chandigarh Administration* [(2009) 9 SCC 1], the Court has expressed the view that the right of a woman to have reproductive choice is an inseparable part of her personal liberty, as envisaged under Article 21 of the Constitution. She has a sacrosanct right to have her bodily integrity. The case at hand, as we find, unless the pregnancy is allowed to be terminated, the life of the mother as well as that of the baby to be born will be in great danger. Such a situation cannot be countenanced in Court. Regard being had to the aforesaid and keeping in view the report of the Medical Board, we are inclined to allow the prayer and direct medical termination of pregnancy of the 1st petitioner at the IPGMER-SSKM Hospital. The termination procedure to be carried out forthwith by the competent authorities of the IPGMER-SSKM Kolkata. For the sake of clarity, we may hasten to add that Mr. Gonsalves, upon obtaining instructions, has agreed for the said hospital. When we say, 'carried out forthwith' it depends when the 1st petitioner and her husband go to the hospital, it shall be conducted without any delay. Accordingly, the Writ Petition is disposed of.

The writ petition is disposed of in terms of the signed order.

Outcome

The Bench allowed the termination of the pregnancy by the competent authorities of the IPGMER-SSKM Hospital, Kolkata and with prior informed consent of inherent risk of the petitioner's health for procedural inventions, as there exists an additional risk of terminating beyond the 20 weeks threshold. Moreover, this case was considered to be a 'special case'; therefore, the conclusion was drawn on its individual merits. There was a probable threat to the mental and physical health of the pregnant mother. Also, if the child was born then it wasn't compatible enough with the extra-uterus life (outside the uterus). Therefore, in the interest of everyone, the best option was to terminate the pregnancy.

5. Sheetal Shankar Salvi & Anr. Vs. Union of India & Ors. Writ Petition (Civil) No. 174 of 2017

Facts

Petitioner No. 1 is into her 27 weeks of pregnancy, and the fetus of the petitioner has been diagnosed with Arnold Chairi malformation Type 2 severe hydrocephalus with lumbosacral menigo myelocele and spina bifida with tethered cord, because of this the child may have severe physical and mental morbidity on survival. Moreover, the Medical Board determines that the baby may be born alive and may survive for variable period of time. Furthermore, the mother's physical condition is normal and there is no physical risk to her, however, she is anxious about the outcomes of pregnancy.

Relevant Laws

Constitution: Article 21 (right to a dignified life)

Statuses & Schemes: Medical termination of Pregnancy Act, 1971

International Law: K.I. v. Peru, Communication No 1153/2003, Human Rights Committee, U.N. Doc. CCPR/C/85/D/1153/2003 (2005). Finding that women have the right to safe legal abortions in the case of foetal abnormality, and the denial of the same violates women's right to be free from cruel, inhuman and degrading treatment.)

Order: Supreme Court of India

22nd March, 2017

Petitioner No.1 – Sheetal Shankar Salvi, has approached this Court under Article 32 of the Constitution of India seeking directions to the respondents to allow her to undergo medical termination of her pregnancy.

By order dated 22.3.2017, while issuing notice to the respondents, this Court gave a direction for examination of petitioner no.1 by a Medical Board consisting of the following seven Doctors :

1. Dr. Avinash N. Supe, Director (Medical Education & Major Hospitals) & Dean (G&K) – Chairman
2. Dr. Shubhangi Parkar, Professor and HOD, Psychiatry, KEM Hospital

3. Dr. Amar Pazare, professor and HOD, Medicine, KEM Hospital

4. Dr. Indrani Hemantkumar Chincholi, Professor and HOD, Anaesthesia, KEM Hospital

5. Dr. Y.S. Nandanwar, Professor and HOD, Obstetrics, KEM Hospitals

6. Dr. Anahita Chauhan, Professor and Unit Head, Obstetrics & Gynecology, LTMMC and LTMG Hospitals

7. Dr. Hemangini Thakkar, Addl. Professor, Radiology, KEM Hospital

Petitioner No.1 is into her 27 weeks of pregnancy. This is also borne by the medical report dated 25.3.2017, received from the Dean & Director (ME & MH)'s Office, Seth

G.S. Medical College & KEM Hospital, Parel, Mumbai – 400 012

It is not in dispute that the fetus of petitioner no.1 has been diagnosed with polyhydramnios with Arnold Chairi malformation - Type 2 severe hydrocephalus with lumbosacral meningo myelocele and spina bifida with tethered cord.

The Medical Board has submitted its report dated 25.3.2017. On perusal of the said report, we find that the said report contains the following significant features for the purposes of passing this order : (1) The diagnosis of Arnold Chairi malformation

Type 2 with meningo myelocele with tethered cord has been made on the basis of ultrasonography. (2) The mother's physical condition is normal and there is no physical risk to the mother, due to continuation or termination of pregnancy. But she is anxious about outcome of pregnancy. (3) The fetus has severe physical anomalies which will compromise post natal quality of life and the child will have severe physical and mental morbidity on survival. (4) If the pregnancy is terminated at 27 weeks, the baby may be born alive and may survive for variable period of time. Apparently, it has not been possible for the aforesaid Medical Board to determine the period of time for which the baby is likely to survive. It also appears from the said report that the baby is not likely to survive like a normal baby.

However, having regard to the fact that there is no danger to the mother's life and the likelihood that 'the baby may be born alive and may survive for variable period of time, we do not consider it appropriate in the interests of justice to direct the respondents to allow petitioner no.1 to undergo medical termination of her pregnancy. In fact, the aforesaid Medical Board has itself stated that it does not advise medical termination of pregnancy for petitioner no.1 on medical grounds. The only other ground that appears from the observations made in the aforesaid medical report apart from the medical grounds, is that

petitioner no.1 is anxious about the outcome of the pregnancy. We find that the termination of pregnancy cannot be permitted due to this reason.

In the facts and circumstances of the case, it is not possible for us to grant permission to petitioner no.1 to terminate the life of the fetus.

In view of the above, as at presently advised, we decline the prayer of the petitioners for directing the respondents to allow Petitioner No.1 to undergo medical termination of the pregnancy. Hence, the writ petition is dismissed.

The writ petition is dismissed in terms of the signed reportable order.

Outcome

Having regard to the fact that the mother's health is at no risk and the likelihood that the baby may survive, the court did not consider it to be appropriate in the interest of justice to allow terminating the pregnancy. Moreover, the ground that Petitioner no. 1 is anxious about the outcome of the pregnancy isn't strong enough to permit the termination. Therefore, the prayer of the petitioner got declined. As there was a possibility of the survival of the baby and no risk to the health of the mother, termination of the pregnancy seemed illegitimate on all medical grounds. However, as the Medical Board couldn't determine the period of time the baby is likely to survive, it also seems fair on the mother's half to be anxious about the outcome of the pregnancy

6. Rajashri Nitesh Chadar Vs. Union of India & ors Writ Petition No. 13728 of 2017

Facts

The Petitioner herein, a resident of Chembur, Mumbai, is 22 weeks pregnant, and has been barred from seeking a Medical Termination of her pregnancy in spite of the diagnosis of a foetal abnormality which renders the possibility of survival of the foetus negligible. The instant Petition has been preferred by the Petitioner challenging the constitutional validity of Section 3 (2) (b) of the MTP Act restricted to the ceiling of 20 weeks stipulated therein and scope of section 5 of the Act on the ground of its narrow and literal interpretation, particularly limited to the phrase "the termination of such pregnancy is immediately necessary to save the life of the pregnant woman". The aforesaid challenge primarily questions the rationale behind the period of limitation that has been statutorily prescribed

to be not exceeding a period of 20 weeks for a woman to avail abortion services under section 3 (2) (b) which may have been reasonable when the section was enacted in 1971, but has ceased to be reasonable in the view of stride in technology and it is perfectly safe for a woman to abort even up to the 26th week and thereafter. Secondly, determination of fetal abnormality in many cases can only be done after the 20th week, and by keeping the ceiling artificially low, women who obtain reports of serious fetal abnormality after the 20th week have to suffer excruciating pain and agony on account of the deliveries that they are forced to go through it.

Relevant Laws

Constitution: Article 21 (right to a dignified life)

Statutes & Schemes: Medical termination of Pregnancy Act, 1971

International Law: K.I. v. Peru, Communication No 1153/2003, Human Rights Committee, U.N. Doc. CCPR/C/85/D/1153/2003 (2005). Finding that women have the right to safe legal abortions in the case of foetal abnormality, and the denial of the same violates women's right to be free from cruel, inhuman and degrading treatment.)

Order –High Court of Maharashtra

18th December, 2017.

1. Heard parties through their counsel. With consent heard and finally disposed of.
2. In this petition, on 13th December, 2017 while issuing notice to the respondents, the Medical Board of expert Doctors of Seth G. S. Medical College & KEM Hospital, Parel, Bombay was constituted by this Court to medically examine the petitioner as her pregnancy was stated to be of 22 weeks so as to form opinion whether it would be appropriate to direct respondent no.2 to allow the petitioner to carry out the medical termination of pregnancy in view of the various serious infirmities found in the certificate filed by the petitioner from Nanavati Super Specialty Hospital.
3. In pursuance of the order passed by this Court the Medical Board of G. S. Medical College & KEM Hospital, Parel, Bombay has submitted its report dated 15th December, 2017. On going through the report it appears that the Medical Board has examined the petitioner's physical condition and has given its opinion.
4. The relevant portion of the opinion of the Medical Board reads as under;

“7. Obstetric examination shows about 2224 weeks pregnancy, the petitioner herself is in fair health at present.

8. Ultrasonographic diagnosis is single live fetus with gestational age of 23 weeks with Dandy Walker malformation.

9. As per neurological review, with Dandy Walker malformation. The fetus after birth may have mental retardation, seizures and ataxia. The possible severity of these disabilities cannot be quantified at present.

10. As per pediatric surgical review, there is no surgical cure for Dandy Walker malformation.

11. Preanesthetic assessment- The patient is fit for general/regional anesthesia.”

5. Based upon the aforesaid findings, the Medical Board has stated as under;

“1. The child if born, viable, has possible risk of mental retardation, ataxia and seizures which cannot be quantified at present. 2. If the pregnancy is terminated now as per the patient’s and her family’s request: (a) The most common complication of second trimester medical abortion is retained placenta, which is estimated to occur at a rate of 15% to 50%. (b) Other complications of medical abortion include hemorrhage requiring transfusion (,1%), infection (2.6%), and failed abortion. (c) In advanced gestational age cases induction time is longer and risk of hemorrhage is greater. (d) The mortality rate with abortions performed at eight weeks or earlier was 0.1 deaths per 100000 legal terminations, and rises to 8.9 deaths per 100,000 abortions for those at 21 weeks or later. Mortality with abortions after 20 weeks is higher than that with natural live births. (e) If induction fails, the patient may require hysterotomy for maternal indication; in that case, in future pregnancy there is small chance of rupture of scar (about 1%), the relative risk of morbidly adherent placenta is 3 to 5 (as per available statistics). (f) At present there is no evidence of any physical risk to maternal health owing to the reported fetal malformations.

In view of the above, the Medical Board is of the opinion that termination of pregnancy may have substantial physical risks for the patient. These risks are stated based on available scientific evidence.”

6. We have also noticed that as directed by this Court, in regard to the pros and cons of proposed termination of pregnancy, counseling to the petitioner and her family members was done by the said Medical Board and the petitioner has expressed her willingness to take the risk.

7. Having regard to the aforesaid, in our considered view it would be appropriate to allow the petitioner to terminate the pregnancy as the fetus after birth will be of various serious infirmities as reflected in the opinion as aforesaid, in the circumstances, we allow this petition and direct the petitioner to remain present in the said hospital on 19th December,

2017 so that the termination of pregnancy can be carried out within a day or two as may be deemed fit by the Medical Board.

8. We also make it clear that the Medical Board which has examined the petitioner as per our directions will not be held liable for submitting the report and they will not be held liable for any litigation arising there from. We also make it clear that the petitioner has been made aware about the risk involved in carrying out the medical termination of pregnancy and she has taken the prompt decision to undertake the risk by carrying out the medical termination of pregnancy.

9. We direct learned AGP to appraise the Dean of the said hospital. We also direct Ms. Yadav, counsel who generally appears for Municipal Corporation to inform the said Hospital so that the appropriate arrangement of termination of pregnancy can be done.

10. Parties to act on an authenticated copy of this order.

11. Needless to say that the petitioner will bear the necessary expenses as per the norms of the hospital.

12. With aforesaid directions, petition is disposed of.

7. Gausiya Gulam Pathan vs Union of India & Ors Writ Petition No.13228 Of 2017

Facts

The Petitioner herein, a resident of Ghatkopar, Mumbai, and is the father of a 13 year old girl, who is currently 25 weeks pregnant, and has been barred from seeking a Medical Termination of her pregnancy as the number of weeks of pregnancy has passed the 20 weeks as stipulated under the Medical Termination of Pregnancy Act, 1971.

The victim's physical and mental health has been put in serious risk because of the 20 week time limit in Section 2(b) of the MTP Act.

According to the Indian Academy of Paediatrics chart,¹ at the age of 10, an average Indian female child will weigh 30 kg and be 140 cm tall at the 50th percentile. Given that maternal height of less than 145 cm is a predictor for obstructed labour and increases the risk of a bladder wall fistula during vaginal delivery it is not likely that this child can have a vaginal delivery without causing serious trauma to the perineum and pelvic floor muscles. Of course, the foetus may also be growth retarded and of a low birth weight but it seems

that the delivery will have to be surgical via a caesarean section. This is a major surgery requiring anesthesia. In fact, research shows that the risk of maternal mortality could be five times higher for mothers aged 10 to 14 than for those aged 20 to

24, while babies born to mothers younger than 14 are 50% more likely to die than babies born to mothers older than 20. Teenage mothers are more likely to suffer from obstructed delivery and other severe childbirth- and pregnancy-related complications like obstetric fistula, perineal tear, prolapsed etc. This results in higher morbidity and mortality for them and their children. A third of women are either pregnant or mothers by age 20, and this proportion is not declining, the report observed.

Relevant Law

Constitution: Article 21 (right to a dignified life)

Statuses & Schemes: Medical termination of Pregnancy Act, 1971

International Law: K.L. v. Peru, Communication No 1153/2003, Human Rights Committee, U.N. Doc. CCPR/C/85/D/1153/2003 (2005). Finding that women have the right to safe legal abortions in the case of foetal abnormality, and the denial of the same violates women's right to be free from cruel, inhuman and degrading treatment.)

Order –High Court of Maharashtra

5th December, 2017.

1. Heard learned counsel for the parties. With consent finally disposed of.
2. The Petitioner who is a 13 year old girl and a victim of alleged rape and sexual abuse has preferred this writ petition seeking direction for allowing her to terminate the pregnancy which is of more than 25 weeks.
3. On 30.11.2017 while issuing notice to the respondents, this Court constituted a Committee of Experts of K.E.M.Hospital Mumbai to medically examine the petitioner and submit a report. As per directions of this Court the Expert Committee consisting of (1) Dr.Avinash N.Supe, Director (Medical Education and Major Hospitals) and Dean (G&K) Chairman (2) Dr.Ajita Nayak, Professor, Psychiatry, K.E.M.Hospital (3) Dr.Amar Pazare, Professor and H.O.D. Medicine, K.E.M.Hospital (4) Dr.Indrani Hemantkumar Chincholi, Professor and H.O.D.Anesthesia K.E.M.Hospital (5) Dr. Y.S. Nandanwar, ExProfessor and H.O.D. Obstetrics & Gynecology, L.T.M.M.C and L.T.M.G.Hospital (6) Dr.Padmaja

Samant, Addl. Professor, and Unit Head, Obstetrics & Gynecology, K.E.M. Hospital (7) Dr. Hemangini Thakkar, Addl. Professor, Radiology K.E.M. Hospital and (8) Dr. Ruchi Nanavati Prof & H.O.D. Neonatology, K.E.M. Hospital has been constituted by the said hospital. The Petitioner appeared before the said Medical Board. The Medical Board on examination has submitted its opinion. The salient features of the said opinion reads thus: “(a) On the other hand, pregnancy at this stage (especially with this patient’s challenges) is known to cause severe detrimental effects on the physical and psychological health and emotional well being of a young girl. (b) Continuation of pregnancy may pose additional risk of conditions like pregnancy induced hypertension. (Known to occur in very young pregnant patients) It is the 2nd most common cause of maternal mortality. (c) The patient has also been anemic and was transfused blood to correct the same. Anemia is another important cause of maternal mortality. Thus, we submit that continuation of pregnancy is likely to cause severe physical and mental consequences for the patient. (d) The mental trauma of childbirth will be the same regardless of whether the pregnancy is continued but the guilt of abandoning a fully grown neonate will be additional in case of continuation of pregnancy.”

4. The said opinion is taken on record and marked as Exhibit ‘X’ for identification. The said report/opinion is suggestive of the fact that the termination of the pregnancy at this stage of 25 weeks and three days or delivery at term will have equal risk to the mother. It also suggests that it would be in the interest of the (patient) petitioner that the pregnancy is to be terminated as it may pose danger to the risk on conditions like hypertension and cause of maternal mortality.

5. Considering the age of the petitioner which is only 13 years, the trauma she has suffered because of sexual abuse and the agony she is going through at present and above all the report of the Medical Board constituted by this Court, and also having due regard to the fundamental rights conferred under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the petitioner to undergo the medical termination of pregnancy under the provisions of the Medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery.

6. Accordingly, we allow the petition and direct the petitioner to remain present in the said hospital tomorrow i.e. .12.2017 so that the termination of pregnancy can be carried out within a day or two by the expert team.

7. The learned AGP is directed to apprise the Dean of the said Hospital so that appropriate arrangements for the termination of the pregnancy can be done.

8. In addition, we direct the Law Officer of the Municipal Corporation of Greater Mumbai to inform the said Hospital about passing of this order.
9. Parties to act on an authenticated copy of this order.
10. With aforesaid directions, petition is allowed in aforesaid terms.
11. We are passing this order keeping in view the law laid down by the Supreme Court in case of MURUGAN NAYAKKAR VS UNION OF INDIA & ORS decided on 6.9.2017 in Writ Petition (s) Civil No. (s) 749 of 2017.

8. Savita Ravi Garud vs Union of India & Anr Writ Petition No. 14261 of 2017

Facts

Petitioner was a minor rape survivor, with 25 week old pregnancy. The High Court recognized that by not granting her permission for termination, there would be the violation of her right to life under Article 21, since it will be subjecting her to the risks of maternal mortality. The Court recognized that time was essence in such situations, and ordered that the termination be conducted in an expeditious manner. The termination was shifted from the Rajawdi Hospital- which produced the report on her health- to K.EM Hospital since it had better emergency facilities.

Relevant Law

Constitution: Article 21 (right to a dignified life)

Statutes & Schemes: Medical termination of Pregnancy Act, 1971

International Law: K.L. v. Peru, Communication No 1153/2003, Human Rights Committee, U.N. Doc. CCPR/C/85/D/1153/2003 (2005). Finding that women have the right to safe legal abortions in the case of foetal abnormality, and the denial of the same violates women's right to be free from cruel, inhuman and degrading treatment.)

Order –High Court of Maharashtra

9th May, 2018.

Heard. The respondents waive service. By consent of the parties the petition is taken up for final hearing.

By this petition, the petitioner, through her mother and natural legal guardian seeks permission to medically terminate the pregnancy which has passed the 20 weeks contemplated in the Medical Termination of Pregnancy Act, 1971 (Act). The petitioner is presently stated to be of 16 years of age and a victim of sexual assault and rape. It is stated that the petitioner has suffered immense mental and physical anguish as a result and seeks directions of the Court to allow her terminate her pregnancy to protect her health.

On 4th May, 2018 a Division Bench of this Court constituted a Committee of Experts to form a Medical Board at Rajawadi Hospital under the Dean and experts in the field of Gynecology, Neurology, Paediatrics, Psychology, Radiology and other experts to examine the petitioner and give its opinion whether it would be safe to terminate pregnancy of the petitioner. The Dean Rajawadi Hospital has pursuant to the order passed by this Court on 4th May, 2018 constituted a Board consisting of eight doctors Dr. Vidya V. Thakur, Dr. Sumedha Tiwari, Dr. Kiran Mhatre, Dr. Kanchan Chaudhari, Dr. Prakash Trivedi, Dr. Soumil Trivedi, Dr. Manish Doshi and Dr. Maya Wankhede.

The Board has since submitted a report dated 7th May, 2018 where by the general medical condition of patient has been found to be conducive to carry out the procedure. She is able to go through the procedure of medical termination. The examination included General medical examination as also examination by Radiologist, Psychiatrist, Gynecologist, Pediatrician and Anesthetist. The opinion is taken on record and marked "X" for identification. The opinion of the doctors and conclusions reached by the Panel of doctors are as follows:

1. *Current pregnancy is about 25 weeks by clinical and Sonographic evaluation.*
2. *In our opinion of board, considering the age of the patient (16 years) continuation of pregnancy (24.1 weeks) can lead to complications including mortality and is detrimental to the overall health of the patient.*
3. *The mental trauma of child birth will be the same regardless of whether the pregnancy is continued but the guilt of the abandoning a fully grown neonate will be additional in case of continuation of pregnancy.*

On 7th May, 2018 when this matter was listed before us, the petitioner's mother seemed hesitant at one stage and was unsure as to whether or not pregnancy is to be terminated. However, after consulting the panel of doctors and given the opinion that continuation of pregnancy can lead to complications including mortality and is detrimental to the overall health of the patient, she has since expressed the desire to proceed with termination of

pregnancy. We have also interacted with the mother of victim during the course of hearing and she has stated that her hesitation was only caused due to different reactions of other family members. However, she is today firmly of the opinion that the pregnancy is required to be terminated. The Board is clearly of the view that pregnancy can be terminated as per patient and family members' request.

Today, at the hearing Mr. Godbole, learned counsel appearing on behalf of respondent no.4-corporation, which manages the Rajawadi Hospital has stated that the investigation has also revealed that the consequences of the procedure could be that the foetus may not survive. It is further submitted on behalf of the corporation that rather than the procedure being carried out at Rajawadi Hospital, Ghatkopar it would be appropriate that procedure is conducted at K.E.M. Hospital, Parel, in view of the fact that K.E.M. Hospital has much better facilities including those that may be required in the event of any emergency. In addition, it is submitted that the team of doctors at K.E.M. Hospital is much larger and more accessible in case of emergency when compared to the Rajawadi Hospital.

In the circumstances, having considered all facts and in particular the fact that the petitioner is of a tender age of 16 years and likelihood of mental and physical anguish and trauma she continues to go through and her fundamental right under Article 21 of the Constitution of India to live a life with dignity and in the light of the opinion that continuation of the pregnancy at this tender age of 16 years may lead to maternal mortality, it is appropriate that this Court permits medical termination of pregnancy. In this behalf this Court has in Writ Petition 13228 of 2017 passed a similar order following the decision of the Supreme Court in cases of *Murugan Nayakkar Vs. Union of India* Writ Petition (Civil) No.749 of 2017.

In the circumstances, we allow the petitioner to medically terminate her pregnancy. Considering the fact that time is of essence and any further delay would increase the risk to the petitioner, the Corporation will ensure that the petitioner is transferred from Rajawadi Hospital to K.E.M. Hospital at the earliest possible opportunity and preferably by the end of day today i.e. 9th May, 2018 so that K.E.M. Hospital could conduct all preliminary and precautionary tests required as is done in any normal case of medical termination of pregnancy.

The entire team of doctors comprising the Board of Rajawadi Hospital shall be available for consultation with the team at K.E.M. Hospital. In conclusion, we make it clear that all necessary precaution be followed in terms of the Act and Rules framed thereunder and shall be observed by the K.E.M. Hospital. The Dean of K.E.M. Hospital shall ensure that all

necessary arrangements are made forthwith to avoid any procedure delay for commencement which in any case should commence preferably tomorrow i.e. 10th May, 2018.

The Law Officer, Municipal Corporation shall also inform the hospitals in question about this order to ensure timely compliance.

All concerned to act on an authenticated copy of this order. Meanwhile Mr. Godbole states that he will ensure that all necessary action will be taken by the hospitals concerned without awaiting an authenticated copy of this order.

The petition is allowed in the aforesaid terms and is disposed off accordingly.

The Report dated 7th May, 2018 shall be retained in the Registry in a sealed cover.

9. Rupali Chetan Kumbhar vs Union of India & Ors Writ Petition No. 2020 of 2018

Facts

The Petitioner was 24 weeks pregnant. A committee report by J.J Hospital as directed by the Court, listed neurological abnormalities that the foetus had and that it fulfills category of “Substantial Physical Handicap”.

Taking note of the report of the committee, the court observed that letting her go ahead with the pregnancy with this risk would lead her to live a life of misery and violate her right to life.

Relevant Law

Constitution: Article 21 (right to a dignified life)

Statuses & Schemes: Medical termination of Pregnancy Act, 1971

International Law: K.L. v. Peru, Communication No 1153/2003, Human Rights Committee, U.N. Doc. CCPR/C/85/D/1153/2003 (2005). Finding that women have the right to safe legal abortions in the case of foetal abnormality, and the denial of the same violates women’s right to be free from cruel, inhuman and degrading treatment.)

Order –High Court of Maharashtra

1st March, 2018

1. Petitioner Rupali Chetan Kumbhar has approached this court under Article 226 of

the Constitution of India seeking direction to the first respondent to produce a report of the appropriate committee which may be constituted by this court for examination of the petitioner and for submitting its report as to whether the petitioner can be allowed to get the pregnancy terminated.

2. According to the petitioner, pregnancy has gone upto 24 weeks which is beyond the permissible period of 20 weeks, in the circumstances, petitioner has approached this court.

3. On 21.2.2018 while issuing notice to the respondents, this court has directed constitution of the committee consisting of various experts from Sir JJ Group of Hospitals, Mumbai. The said Committee after examining the medical reports submitted by the petitioner and after conducting various tests upon her, submitted its report. The relevant portion of the report of the said expert committee reads thus:

“THE COMMITTEE AFTER EXAMINATION AND CAREFUL STUDY OF MULTIPLE SONOGRAPHY REPORTS, HAS CONFIRMED THAT THE FETUS HAS A NEUROLOGICAL ABNORMALITY IN THE FORM OF:

1. *ABSENCE OF CAVUM SEPTUM PALLIDUM*
2. SQUARING OF FRONTAL HORNS OF BOTH LATERAL VENTRICLES
3. AGENESIS OF CORPUS CALLOSUM
4. COLPOCEPHALY
5. SEPTO OPTIC DYSPLASIA CANNOT BE RULED OUT. THIS CAN RESULT IN:
 1. DELAYED DEVELOPMENT.
 2. RESISTANT EPILEPSY
 3. INTELLECTUAL IMPAIRMENT
 4. PSYCHOSIS
 5. VISUAL DEFECTS
 6. SPASTICITY/CEREBRAL PALSY
 7. AUTISM/ADHD/DYSLEXIA

SUCH CASES ALSO MAY BE ASSOCIATED WITH:

1. MIGRATIONAL DISORDERS

2. PVL
3. INTRAAVENTRICULARHAEMORRHAGE
4. MICROCFEPHALY OR HYDROCEPHALUS
5. VARIOUS SYNDROMES LIKE AIRCARDES SYNDROME AND OTHERS.

THUS THE CONDITION OF FETUS FULFIL THE CRITERIA OF “SUBSTANTIAL RISK OF SERIOUS PHYSICAL HANDICAP.” THE PREGNANCY HAS ADVACNED UPTO 24 WEEKS AND IS BEYOND 20 WEEKS CUT OFF OF MEDICAL TERMINATION OF PREGNANCY ACT. HENCE, SHE HAS APPROACHED THE HONOURABLE COURT FOR TERMINATION OF PREGNANCY.

IF THE HONORABLE COURT PERMITS PREGNANCY CANBE TERMINATED AS DESIRED BY PREGNANT WOMAN. THE RISK OF TERMINATION OF PREGNANCY IS NOT GOING TOBE MORE THAN THAT OF NORMAL LABOUR.”

4. We have gone through the said opinion which includes opinion of the various expert doctors including Dr.Ashok Anand, Professor and Head, Dept of OBGY, GGMC, Mumbai, Dr. V.P. Kale, Professor and Head, Dept of Psychiatry, GGMC, Mumbai, Dr. Shilpa Domkundwar, Professor and Head, Dept of Radiology, GGMC, Mumbai, Dr. Bela Varma, Professor and Head, Dept of Pediatric, GGMC, Mumbai, Dr.Kamlesh Jagyasi, Dr. Kamlesh Jagyasi, Professor and Head, Dept of Neurology, GGMC, Mumbai. It appears that the Committee has reached the conclusion that there would be substantial risk of serious physical handicap.

5. Having regard to the aforesaid, it is very difficult for us to refuse permission to the petitioner to undergo the medical termination of the pregnancy. It is certain that if the petitioner is allowed to give birthtofoetus, there is substantial risk of serious physical handicap.

6. In view of the above peculiar circumstances and having due regard to the fundamental right conferred on the petitioner under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the petitioner to undergo the medial termination of pregnancy under the provisions of the medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery.

7. The learned AGP as also the learned counsel for the Union of India have not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.
8. We further direct that the termination of the petitioner's pregnancy to be performed within three days by the expert doctors of Sir, J.J. Group of Hospital, Mumbai where she has to undergo medical check up.
9. The termination of the pregnancy will be supervised by the Committee/Medical Board constituted by this court which shall maintain the complete report of the procedure which would be performed on the petitioner at the time of termination of the pregnancy.
10. We also make it clear that in the event of any problem in connection with the medical termination of the pregnancy, the doctors of the Medical Board shall have immunity in law.
11. Petitioner shall bear the cost of the operation and other expenses.
12. With the aforesaid directions, petition is disposed of.
13. Parties to act on authenticated copy of this order

Coercive Sterilization

Female sterilization in India overwhelmingly dominates the contraceptives method mix used across the country, at a colossal 75%. In addition to this, 85% of the family planning budget is used for promoting and implementation of female sterilization through camps in rural India. Through these camps, women continue to be pushed into the procedure, often with a glaring lack of informed consent. Sterilization in India has long been used as a means of target-driven population control, disregarding the reproductive autonomy of women in favour of curbing population growth. Although the National Population Policy 2000 broke new ground in prioritizing reproductive rights over population control, the existence of sterilization camps and the rampant, disproportionate promotion of the procedure demonstrate that implementation 18 years on remains to be fully realized.



The picture shows the unhygienic and negligent conditions which a woman faces during treatment at a government hospital.

In 2015, the Devika Biswas Vs Union of India case challenged appalling sterilization camps that were taking place across the country, rounding up poor women and loading them like cattle into abandoned schools, sterilizing them in barbaric and highly unsanitary conditions, without anesthesia. These camps resulted in many deaths and in the overwhelming majority of cases, the women did not consent to the procedure—many of them were young and in the reproductive age group of 18-39. In a landmark judgement, the Supreme Court outlawed the camps and directed various states to provide compensation to the families of the victims.

Nevertheless, sterilization in India is still problematic. Ground level health workers are heavily incentivized to encourage women to undergo the procedure, rather than promoting condom or oral contraceptive pill usage. Sterilization remains a procedure that is performed at a disproportionately high rate when compared with other nations. Mentioned below are few of the leading cases done on coercive sterilization:

1. Smt. Komal Bai vs. State of Madhya Pradesh and Ors. W.P No. 3634/2016

Synopsis

Komal Bai got married to Lakhan Rajput at the age of 19. After a year she gets pregnant and first child, Arun was delivered at Sehore hospital. Due to a Caesarian delivery, she was asked to remain admitted in the hospital for 9 days. During labor pain she was taken to Kalapeepal and from there she was referred to Sehore dist hospital but CHC do not bother to provide ambulance and Lakhan had to hire private vehicle even after delivery the ambulance was not provided and Lakhan has to spend an amount Rs 2000 for hiring vehicle. After delivery all the checkups and vaccination were conducted in the AWC. Neither Komal nor Lakhan were aware or informed about any contraception by the health centers.

After 2 years she again conceived and went to Kalapeepal and was referred for Sehore hospital and she then again she had to go through surgical operation for delivery and again Lakhan has to hire private vehicle and spend Rs 3000. For both surgical operation, she received Rs 1400, both the times, all the vaccination and health checkup were conducted in AWC. After the safe delivery of both the child both Lakhan and Komal decided for family planning therefore Komal decided to go through TT. ASHA informed them about sterilization camp in Kalapeepal and therefore Komal went to Kalapeepal for sterilization

on 11/8/2011, at 11 am she went to the camp after Komal signed the consent letter Komal gone through sterilization at 3:59 pm and her name was registered.

After the sterilization she received Rs 600 for sterilization from the sterilization camp. She was not informed about the risk of failure neither any of the health worker went to check Komal's health. Due to lack of information both Komal and Lakhan thought that there was no chance of a 3rd pregnancy. After 2 months of TT, Komal didn't menstruate in the 3rd month not even in fourth, so they decided to go and visit the health centre at Kalapeepal. On 16/11/2011 she went to Rogi Kalyan Samiti, Kalapeepal, Government hospital Kalapeepal, Dist. Shajapur Department of Pathology, Komal's urine test was conducted, it was found to be positive and it was because of the failure of LTT.

Komal and Lakhan were suggested that they can still abort the child and after 3 days, they both went to Dr K.K.joshi, M.B.B.S. M.D USG trained in Gandhi medical college and Hamidia hospital Bhopal on 19/11/2011 for abortion and Dr K.K. Joshi completed the process of abortion. Lakhan requested health centre of Kalapeepal for recompense for failure of sterilization on 12/1/2012 and also wrote an application to Ashish Shrivastav, area head of ICICI Limbart, Alankar palace zone II MP Nagar (Bhopal) for the recompense for the failure of sterilization.

Facts

This petition showed that Komal Bai (the petitioner) in August, 2011 had underwent a sterilization operation at the Kalapipal CHC in Shajapur in Madhya Pradesh, However, due to a failure of the surgery, Komal became pregnant later. The petition thus sought compensation for the state's failure and the trauma endured by Komal.

Komal had been married at the age of 19 and after two complicated and expensive pregnancies, she and her husband decided to opt for family planning services, following which she underwent the sterilization operation. Since she was illiterate, she could not read the consent form she was given to sign and nobody translated it for her from English. Furthermore, no one counseled her or her husband about the procedure, post-surgery care, or the possibility of failure and available compensation. Due to their ignorance, she and her husband were sure that there was no chance of a third pregnancy.

But after the failure of the sterilization procedure, Komal became pregnant a third time and had to seek an abortion.

Order

05.07.2017

Resultantly, the writ petition stands allowed with a direction to the Chief Medical and Health Officer, Shajapur to pay a sum of Rs.30,000/- to the petitioner within a period of 60 days from the date of receipt of certified copy of this order. In case, the amount is not paid within 30 days to the petitioner, the same shall carry interest @ 12.5% per annum from 24/08/2011 till the amount is actually paid to the petitioner.

Outcome

The petition argued that the state's failure in ensuring Komal's reproductive rights was in violation of her fundamental right to life, to health, to equality, and to dignity. The state also failed to fully and adequately implement standards set by Supreme Court's order Ramakant Rai vs. Union of India.

It further noted that this failure of sterilization procedure entitled Komal to "Rs 30,000 as per Section N of the Family Planning Indemnity Scheme, 2013 and the amount of Rs 2 lakh for the suffering and mental illness."

After perusal of case laws and considering the matter at hand, the court, in its final order directed the Chief Medical and Health Officer, Shajapur to pay Rs 30,000 to Komal Bai within a period of 60 days.

2. Devika Biswas Vs. Union of India and Ors. Supreme Court W.P. (C) 95/ 2012

Synopsis

In spite of the Supreme Court's orders in the significant Ramakant Rai case, forced and unsanitary sterilizations continue throughout India. Often held at public locations like government schools, these camps typically target poor, tribal and dalit women. Women are sterilized without consent because the nature of the procedure is not explained to them and as a result of negligent treatment many women eventually succumb to infection and death.

Facts

In January 2012, up to 53 women underwent a sterilization procedure in Bihar, India, at

a sterilization camp managed by an NGO which had been granted accreditation by the District Health Society, apparently without following any formal, transparent process. The women had not been given any counseling regarding the potential dangers and outcomes of the sterilization procedures. They were operated on in a school rather than a hospital, in an unsanitary and unethical manner, all by a single surgeon, under torchlight on top of a school desk, and without running water or sanitary gloves. Many of the women experienced tremendous physical pain post-operation, and consequently filed police complaints. Subsequent investigation by State authorities found that the camp had largely been a success, save for its use of expired medicine.

Following her own investigation, the petitioner, health rights activist Devika Biswas, claimed before the Supreme Court of India (Court) that these incidents constituted a violation of the Constitution of India (Constitution). The petition requested a full investigation into, and redress for, the 2012 incidents. Further, to prevent similar violations in the future, the petition also requested orders regarding strict implementation of the sterilization procedure manuals previously issued by the Government of India, following the 2005 Supreme Court decision in *Ramakant Rai (I) & Anr. v. Union of India & Ors.* (*Ramakant Rai*), in adherence to which the Government had published multiple manuals establishing procedural and substantive guidelines for female and male sterilization under family planning or public health programs, including regarding quality assurance and standard operating procedures (Procedure Manuals).

Setting out the context for these incidents, the petition highlighted other sterilization camps in states across India where similar procedures were conducted in unsanitary and unsafe conditions, and where women were either not provided any information regarding the nature of the procedure or were outright misled, for example being told by government health workers that it was compulsory to undergo sterilization. In addition, the petition focused on the reality that an overwhelming number of sterilization procedures in India – close to 100% – are targeted towards women.

Order

14.09.2016

1. This public interest petition raises very important issues concerning the entire range of conduct and management, under the auspices of State Governments, of sterilization procedures wherein women and occasionally men are sterilized in camps or in accredited

centers. The issues raised also include pre-operation procedures and post-operative care or lack of it. A sterilization surgery does not appear to be complicated and yet several deaths have taken place across the country over the years. Undoubtedly, this needs looking into by the Government of India and the State Governments and remedial and corrective steps need to be taken. Persons who are negligent in the performance of their duties must be held accountable and the victims and their family provided for. It is time that women and men are treated with respect and dignity and not as mere statistics in the sterilization program.

2. The Petitioner Devika Biswas is a public spirited individual of Araria district in Bihar. She is a health rights activist with extensive professional experience in the development and health sectors. She has worked in Uttar Pradesh, Delhi, Jharkhand and Bihar in her capacity as a health rights activist. She has also been associated with the Integrated Child Development Scheme in Bihar and has published articles and books in her field of specialization.

3. Sometime in 2005 the issue of sterilization procedures for females and males under the Population Control and Family Planning program or the Public Health program of the Government of India came up for consideration before this Court in a petition filed by Ramakant Rai. The petition was substantially decided by this Court on 1st March 2005 by passing several directions. The directions are reported as *Ramakant Rai (I) and Anr. v. Union of India and Ors.* (2009) 16 SCC 565.

4. Pursuant to the directions given by this Court, the Government of India published a Quality Assurance Manual for Sterilization Services (in 2006); Standards for Female and Male Sterilization (in 2006); and Standard Operating Procedures for Sterilization Services in Camps (in 2008). These manuals really form the procedural and substantive basis for conducting sterilization procedures both of females and males in the country under the population control and family planning program or the public health program.

5. What seems to have provoked Devika Biswas in filing a writ petition Under Article 32 of the Constitution in this Court is that on 7th January 2012 as many as 53 women underwent a sterilization procedure in a camp in highly unsanitary conditions in Kaparfora Government Middle School, Kursakanta, Araria district in Bihar between 8 p.m. and 10 p.m. through a single surgeon. In fact, some of the broad issues concerning the sterilization camp held on 7th January 2012 as found on investigation by Devika Biswas, included an absence of pre-operative tests on the women or proposed patients; they were not given any counseling of any kind at all; they had no idea about the potential dangers and outcomes of the sterilization procedure; the sterilization procedures were carried out in a school and not in a government

hospital or a private accredited hospital; running water was not available at the site; the sterilization procedures were carried out under torch light with the women being placed on a school desk; the surgeon did not have any gloves or at least did not change the gloves available with him; no emergency arrangements were made etc. etc. Essentially, the entire camp was conducted in unsanitary conditions, in an unprofessional and unethical manner. What is worse is that the camp was conducted under the auspices of an NGO called Jai Ambey Welfare Society who had been granted accreditation by the District Health Society only a few months earlier that is on 29th November, 2011 apparently without following any formal and transparent procedure.

6. As a result of the sterilization camp, many women who were operated upon underwent tremendous physical pain and anguish and were traumatized. Consequently, a series of complaints were filed and they were registered at Kursakanta Police Station on 8th January 2012 being S.DE. No. 135/12, 136/12, 137/12 and 144/12. Some of these complaints were inquired into by the State authorities and it was found that the sterilization camp was a success except that an expired medicine had been given to the women. On the other hand, the study and the investigations carried out by Devika Biswas along with a journalist called Francis Elliott concluded that the sterilization camp did not meet any of the requirements laid down by this Court or by the Government of India and that this was confirmed by the women who were operated upon as well as their relatives.

7. Devika Biswas then felt compelled to file a public interest litigation in this Court to ensure that sterilization procedures nationwide are conducted in accordance with accepted legal norms, medical procedures and the provisions of the manuals and that those women and men who suffer due to the failure or complications in implementing the norms, procedures and provisions are given adequate compensation. That is really the core issue raised by Devika Biswas and that such instances are not repeated.

8. In this context, Devika Biswas says in her writ petition that on 9th February 2008 the State Health Society in Bihar issued a memorandum to the Civil Surgeon in each district in the State. The result of this memorandum was that sterilization procedures could now be conducted in accredited private health facilities also in a camp mode. The memorandum also mentioned that the State Government would provide funds to the private facilities and the motivators as per the Government of India norms for conducting sterilization procedures. However it was made clear that extra funds for camp management, transportation etc. would not be provided by the Government to the accredited private facilities.

9. This was followed by another memorandum dated 9th February 2009 regarding

sterilization procedures carried out at government institutions by empanelled private doctors. The memorandum issued by the State Health Society of Bihar to the Civil Surgeon in all districts stated that an empanelled private doctor might also be permitted to carry out family planning sterilization procedures in government institutions. The Quality Assurance Committee of the district was entitled to employ private doctors including contractual doctors whose term had expired for carrying out the sterilization procedures.

10. The petition filed by Devika Biswas goes on to say that in 2010 a Non Government Organization (NGO) called the Centre for Health and Social Justice released a report concerning the quality of care and consequences of female sterilization procedures in Bundi district of Rajasthan in 2009-10. According to the report 749 women (mainly underprivileged) were sterilized at Public Health Centres, Community Health Centres or Camps. They were interviewed by researchers who found that a significant number of them were not counseled about the permanent nature of the sterilization procedure and almost 88% of them told the researchers that they did not receive any information about potential complications, failures or side effects of the sterilization procedure. The report indicated that while the internationally accepted failure rate is 0.5% the failure rate in Bundi district in Rajasthan was 2.5% that is 5 times the acceptable international standard.

11. Similarly, in February 2012 a Fact Finding Mission by a social activist reported that sterilization procedures carried out in three districts in Maharashtra, that is, Nagpur, Chandrapur and Gadchiroli found that sterilization camps were routinely conducted in unsanitary and unsafe facilities.

12. Again in February 2012 a sterilization camp in Madhya Pradesh was conducted in Balaghat district without following any of the established procedures and tribal's were lured into sterilization camps by motivators who collected a substantially large amount over and above the financial norms fixed by the Government of India.

13. In Kerala also a similar story was repeated in July 2011 highlighting that sterilization procedures were not conducted in accordance with the prescribed requirements of law or the procedures were laid down by the Government of India. In paragraph 40 of the writ petition, Devika Biswas submits that "In July 2011, a local journalist in Wayanad and the Chief of the Kattunayakan tribe, who serves as the President of the Primitive Tribal Association, met with health workers in Kerala. They shared stories of men and women who were told by the government health workers that it was compulsory to undergo sterilization. The Chief is concerned about government coercion and compulsion in sterilization and its effect on the tribe's population."

14. In this background, Devika Biswas prayed for a series of directions including setting up a committee to investigate the facts relating to the sterilization camp held on 7th January 2012 and to initiate departmental and criminal proceedings against those who were involved in the sterilization camp. It is also prayed that the guidelines given in the manuals prepared by the Government of India should be scrupulously adhered to so that such incidents do not recur in any part of the country and if they do, additional compensation should be paid to the women in distress.

15. In this writ petition, we are primarily concerned with the affidavits of the Union of India, the States of Bihar, Kerala, Madhya Pradesh, Maharashtra and Rajasthan since allegations have been made in respect of sterilization camps held in these States only. However, during the course of hearing of this writ petition, allegations surfaced with regard to sterilization camps conducted in Bilaspur district, Chhattisgarh [between 8th and 10th November 2014] and so we are also concerned with the allegations made in respect of the camps conducted in that State as well.

16. What was brought to our notice with regard to the sterilization camps conducted in Bilaspur district was that as many as 137 women were subjected to a sterilization procedure and unfortunately 13 of them died. Many others complained of problems such as vomiting, difficulty in breathing, severe pain etc. They were taken to nearby hospitals and discharged after necessary treatment. It appeared that some women who had not undergone a sterilization procedure also had similar complaints and some of them died thereby increasing the number of deaths to over 13. Undoubtedly, this was a matter of great concern brought to our notice during the pendency of the writ petition.

Orders passed by this Court

17. Notice in the writ petition was issued on 2nd April 2012 and thereafter the petition was taken up for active consideration only on 30th January 2015 when the Social Justice Bench of this Court was seized of this matter and after completion of pleadings and instructions received by the learned Additional Solicitor General from the Union of India.

18. On 30th January 2015 after hearing learned Counsel, a request was made by us to the learned Solicitor General to ensure that a chart be prepared giving the status of implementation of each direction given in *Ramakant Rai (I)*. Details with regard to the implementation of the Family Planning Indemnity Scheme, 2013 were also sought particularly with regard to the release and utilization of funds under the said Scheme.

19. During the hearing, the events in Bilaspur, Chhattisgarh (mentioned above) also came up for consideration and so the State of Chhattisgarh was required to file an affidavit stating the steps taken to ameliorate the conditions of the persons who had faced the recent tragedy. The State Government was also required to indicate the action taken against the doctors involved and steps taken to educate the people in Chhattisgarh with regard to the sterilization procedure and its impact.

20. The petition was then taken up for consideration on 20th March 2015 when it was noted that even though Chhattisgarh had filed an affidavit dated 19th February 2015, it had not given sufficient particulars and details with regard to the action taken subsequent to the mishap in the sterilization camp. Chhattisgarh was therefore required to file a proper and detailed affidavit including a copy of a sample FIR, post mortem report and charge sheet filed, if any.

21. With regard to an affidavit filed by the Union of India in relation to the implementation of the Family Planning Indemnity Scheme, 2013 it was noted that the manner of utilization of funds was not indicated. The learned Solicitor General assured this Court that full details in this regard would be furnished and also an audit would be conducted to ensure that the funds are utilized for the purpose for which they have been given by the Government of India to the State Governments. Unfortunately, these details have not yet been furnished and we have only the figures giving the budget approved as well as the expenditure incurred by the State Governments and Union Territories.

22. On 17th April 2015 the writ petition was again taken up for consideration and as an interim measure the Secretary in the Ministry of Health and Family Welfare of the Government of India was directed to hold a meeting with his counterparts in the States and the Union Territories to arrive at a consensus on the effective implementation of the various schemes relating to sterilization [of females and males], the Family Planning Indemnity Scheme, 2013 and the directions given in Ramakant Rai (I).

23. Chhattisgarh was also required to file a Status Report on the progress made by a Commission set up by it (the Ms. Anita Jha Commission) to look into the tragedy that had occurred in the sterilization camps held in Bilaspur.

24. The learned Advocate General appearing for the State of Chhattisgarh stated that he would look into the issue of taking action against the manufacturer of the drug used in the sterilization camps and the feasibility of filing a charge sheet against the offenders and to step up efforts to arrest the absconding persons or if necessary to declare them proclaimed offenders.

25. In the hearing on 14th August 2015 it was noted that the Secretary in the Ministry of Health and Family Welfare had held a meeting, as earlier directed, on 15th May 2015. It was noted that one of the suggestions given in that meeting was that similar high level meetings should be conducted every six months. Accordingly, we expected the Secretary in the Ministry of Health and Family Welfare to conduct a similar meeting after six months that is on or about 15th November 2015.

26. As far as Chhattisgarh is concerned, it was noted that it had filed an affidavit and the learned Advocate General stated that the Ms. Anita Jha Commission submitted its report on 10th August 2015 and that the report was likely to be considered by the State Cabinet in the next couple of weeks.

27. The learned Advocate General informed us that two charge sheets had been filed in connection with the tragedy and that no FIR was pending investigation. He further stated that some scientific reports were expected from a Forensic Science Laboratory and a supplementary charge sheet would be filed, if necessary, immediately thereafter.

28. With regard to two absconding persons concerned with the tragedy, it was stated by the learned Advocate General that they had been declared proclaimed offenders and a reward had also been announced for their whereabouts.

29. In the hearing on 4th December 2015 we were informed that the report given by Ms. Anita Jha had since been accepted by the State Cabinet. Subsequently, on 29th March 2016 we were informed that an Action Taken Report on the Ms. Anita Jha Commission Report had been placed before the Legislative Assembly.

30. Since the proceedings in this case were not adversarial in nature we requested the learned Additional Solicitor General appearing in the matter as well as the learned Senior Counsel to sit down and give suggestions on how to implement the Standard Operating Procedures and the Guidelines laid down by the Union of India in the matter of sterilization procedures.

31. On 4th August 2016 when we heard the writ petition, we were informed that a meeting was in fact held between the learned Additional Solicitor General, learned Senior Counsel for Devika Biswas and officials of the Ministry of Health and Family Welfare of the Government of India and that an affidavit in this regard had also been filed. We then heard learned Counsel for the parties and reserved judgment.

Affidavits filed by the Union of India

32. The Ministry of Health and Family Welfare of the Government of India has filed as

many as 10 (ten) affidavits. It is not necessary to traverse each of them in detail. However, it is necessary to highlight the broad submissions made. These are:

- (i) It is admitted that the Union of India received a complaint with regard to the sterilization camp held on 7th January 2012 and a report had been called for in this regard. A report has since been received from the concerned authorities in the State of Bihar and Dr. Abhay Kumar Chowdhary, a contract physician at the Primary Health Centre had since been dismissed and it had further been ordered that he may not be employed in any government work in future. First Information Reports (FIRs) were lodged in respect of the events of 7th January 2012, investigations have concluded and charge-sheets filed.
- (ii) The Government of India has published several Manuals for the guidance of the State Governments and Union Territories in respect of sterilization procedures and conducting such camps. These are:
 - (a) Standards for Female and Male Sterilization, 2006;
 - (b) Quality Assurance Manual for Sterilization Services, 2006;
 - (c) Standard Operating Procedures for Sterilization Services in Camps, 2008;
 - (d) Fixed Day Static Approach for Sterilization Services, 2008;
 - (e) Family Planning Insurance Scheme;
 - (f) Compensation Scheme for Acceptors of Sterilization (revised on 31st October 2006 and improved with effect from 7th September 2007);
 - (g) Standards and Quality assurance in Sterilization Services, 2014 including Standard Operating Procedure for camps;
 - (h) Reference manual for Female Sterilization, 2014;
 - (i) Reference Manual for Male Sterilization, 2013;
 - (j) Manual for Family Planning Indemnity Scheme, 2013 (updated in 2016);
 - (k) Frequently Asked Questions, 2016.
- (iii) Public Health is a State subject occurring in Entry 6 of List II of the Seventh Schedule of the Constitution. The Government of India only plays a supportive and facilitative role in achieving health welfare schemes and it is essentially the State Government that is in the best position to monitor the quality of services in accordance with agreed benchmarks.

(iv) The following funds have been approved and utilized (in lakhs) by the States under the Family Planning Indemnity Scheme, 2013:

Approval 2013-14	Expenditure 2013-14	Approval 2014-15	Expenditure 2014-15 (till end of 3 rd quarter)
1566.69	675.59	1485.80	828.19

At this stage it may be mentioned that the coverage under the Family Planning Indemnity Scheme is as follows:

Section	Coverage	Limits
1.	Death following sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital	Rs. 2 Lakh
2.	Death following sterilization within 8-30 days from the date of discharge from the hospital	Rs. 50,000/-
3.	Failure of sterilization	Rs. 30,000/-
4.	Cost of treatment in the hospital and upto 60 days arising out of complication following sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge.	Actual not exceeding Rs. 25,000/-
5.	Indemnity per doctor/health facilities but not more than 4 in a year	Up to Rs. 2 lakh per annum

The Union of India has given no clear-cut answer regarding audit of disbursement of the amounts, except to say that the States and the Union Territories are required to follow the financial management system and are required to submit statutory audit reports, utilization certificates, quarterly summary on concurrent audits etc. Whether this is being adhered to by the States and the Union Territories is not mentioned. It is also not clear whether the accounts of the various organizations involved in sterilization procedures are in fact open for inspection by the sanctioning authority and audit including the Comptroller and Auditor General of India and the internal audit of the Ministry of Health and Family Welfare of the Government of India.

(v) The Union of India has issued an advisory to all the States and Union Territories on 30th December 2014 to adhere to the standard operating procedures at all levels to prevent and pre-empt incidents that might adversely affect the health of clients due to sterilization procedures.

(vi) In the high level meeting held on 15th May 2015 (pursuant to orders passed by this Court) the following key action points were agreed upon:

- (a) Sterilization services must be provided in a client friendly manner in a conducive environment after taking informed consent. Safety of those who opt for it should be ensured.
- (b) A mechanism be put in place wherein service providers or managers are not victimized or arrested without instituting a proper enquiry by the district/State quality assurance committees.
- (c) All States to conduct workshops on quality in sterilization services orienting its programme managers and service providers both at the State and district level on the updated manuals on standards, male and female sterilization and family planning indemnity scheme.
- (d) All Government of India guidelines to be strictly adhered by the States.
- (e) A periodic assessment of all the facilities and fixed day camps by 1-2 members of the sub-committees under the SQAC/DQACs [State Quality Assurance Committee/ District Quality Assurance Committee] on implementation of the infection prevention protocols as well as the efficacy of the services provided, should be carried out (as laid down in the Manuals).
- (f) The issue of shortage of pool of providers for sterilization could be addressed by resorting to compulsory training of MBBS medical officers when they join government service.
- (g) Onsite Training/mentoring be initiated by identifying high caseload facilities (first) to undertake sterilization trainings. This will ensure the service provider is available at the facility to undertake their primary task of providing services to the clients in addition to provide training to prospective trainees.
- (h) Retraining of providers who are either short on confidence or have high failure rates.
- (i) There should be more thrust on Minilap Sterilization as it leads to fewer failures and complications.
- (j) The scope of increasing the basket of contraceptive choices like Injectibles /implants and weekly pills like 'Saheli' be explored urgently to provide more choice.
- (k) The idea of mobile teams or clinical outreach teams needs to be encouraged to address the issue of shortage of surgeons.

- (l) Every case of sterilization death must be audited as per format laid down and reported to the Government of India.
 - (m) Line listing of deaths and failures to be undertaken district/facility wise and surgeon wise. Disbursal of claims for deaths, failures and complications should be computerized.
 - (n) To address the issue of sterilization failures, sterilization certificates should be issued after at least one month in case of female sterilization and after three months in case of male sterilization.
 - (o) States to take urgent steps to rejuvenate the Family Planning Programme with the ultimate aim of reducing the maternal and infant mortality and morbidity in addition to achieving population stabilization.
 - (p) Government of India to conduct high level meeting like the instant one with all States to acquaint them with the latest policies and programmes of the Government of India on a yearly basis.
- (vii) In the high level meeting held on 17th November 2015 (pursuant to orders passed by this Court) the following key priority areas were shared with the State Governments and Union Territories:
- (a) Uniform consent forms should be available in all facilities which should be duly filled in and the consent of the client should be taken prior to the procedure in all cases.
 - (b) State Quality Assurance Committee (SQAC)/District Quality Assurance Committee (DQAC) and State Indemnity Sub Committee (SISC)/District Indemnity Sub Committee (DISC) to be constituted as per the GOI guidelines.
 - (c) All the Family Planning guidelines should be printed and disseminated at the State/district as well as facility level.
 - (d) State/District level orientation of all the program managers and providers for the guidelines and protocols to be completed in all States.
 - (e) Members of SQAC and DQAC should conduct periodic supportive supervision visits as per quality protocols. The findings of the same are to be documented and corrective actions should be taken.
 - (f) Training calendar for training newly recruited doctors is to be prepared and updated in each State.

- (g) Line listing of all the sterilization providers needs to be prepared and periodically updated by all States.
- (h) Every death attributable to sterilization should be audited.
- (i) Sterilization certificates should be issued as per existing guidelines.

The aforesaid meeting was held through video-conferencing. The representative of Uttar Pradesh could not attend due to a State holiday and since the office of the National Informatics Centre in the State was closed. It may be mentioned that this is somewhat odd and suggests that responsible officers in the State of Uttar Pradesh seem to give more importance to State holidays rather than issues relating to Family Planning. This is most unfortunate, to say the least.

- (viii) A National Summit on Family Planning was held on 5th and 6th April 2016. As a result of several workshops and summits held from time to time on issues relating to family planning and the directions given by the Court from time to time the following practical and pragmatic measures were proposed by the Government in addition to the new guidelines proposed to be undertaken:
 - (a) Conducting annual review workshops of the programme in all States of India with the State and district programme managers and service providers.
 - (b) Monthly monitoring of at least 2 public health facilities and 1 accredited private/ NGO facility by SQAC/DQAC.
 - (c) Replacement of operational 'Camps' by regular 'Fixed day services' over the next three years.
 - (d) Further Strengthening of the State Quality Assurance Committee (SQAC) and District Quality Assurance Committee (DQAC) mechanism.
 - (e) Close monitoring, reviewing and collection of reports of deaths attributable to sterilization by the Government of India.
 - (f) Conducting Client exit interviews of 10% cases as per the prepared checklist.
 - (g) Feedback from beneficiaries by Maternal and Child Health Tracking Facilitation Centre (MCTFC).
- (ix) Our country has adopted a comprehensive RMNCH+A (Reproductive, Maternal, Neonatal, Child and Adolescent Health) strategy under which the Family Planning program is being emphasized to promote reproductive health and reduce maternal, infant and child mortality and morbidity.

- (x) The States of Tamil Nadu, Maharashtra, Sikkim and Goa have already phased out the holding of sterilization camps. During the course of submissions we were informed by the learned Advocate General for Chhattisgarh that that State has also phased out such camps. As far as the Union of India is concerned, it proposes to ensure the phasing out of such camps over the next three years.
- (xi) Several improvements have been made in the Family Planning program and sterilization procedures. They are:
- Decline in deaths following sterilization from 140 in 2014-15 to 89 in 2015-16 (as per data available on the web based HMIS till 31.3.2016);
 - Decline in the number of failures from 5928 in 2014-15 to 2093 in 2015-16 (as per data available on the web based HMIS till 31.3.2016);
 - The empanelled list of providers is available in every district;
 - Surgeons are not performing more than 30 cases per day;
 - Camps are being held only in public health facilities or accredited private/NGO facilities.
 - Workshops relating to Family Planning programme have been held in 28 out of 29 States (as on 21st July, 2016). Unfortunately, no such workshops were held after 24th August, 2015.
 - The number of deaths attributable to sterilization procedures in 2014-2015 was 140 but it has come down in 2015-2016 to 113.
 - In 2015-2016 clients exit interviews have been conducted in respect of 1,06,055 persons.
 - Monitoring and supervision of facilities by SQAC/DQAC in 2015-2016 in regard to public facilities is as high as 12,044 and with regard to private accredited facilities it is as high as 2,984.
 - The amount allotted for quality improvement which includes training, family planning equipments, other service delivery activities, human resource cost, infrastructure share, planning and monitoring (including quality assurance) and family planning commodities is as follows:

Year	2013-14	2014-15	2015-16
Amount in Crores	1000.7	1648.07	1243.9

The sum and substance of the affidavits is that it is not as if the Ministry of Health and Family Welfare of the Government of India is sitting idle and not taking adequate interest in the success of the Family Planning program and particularly in sterilization procedures in public and private health facilities. While deficiencies and faults have been pointed out, there has also been considerable improvement in an ongoing exercise of national importance.

Affidavits filed by the State of Bihar

33. The State of Bihar has filed two affidavits, a Status Report and Written Submissions.

34. The broad allegations made by Devika Biswas have been accepted and it is accepted that a sterilization camp was conducted by Jai Ambey Welfare Society (NGO) late in the evening of 7th January 2012 in violation of the orders of the concerned Civil Surgeon. An FIR has been lodged against the NGO not only for violating the directives but also for distributing expired medicine to the beneficiaries of the family planning camp.

35. It is further stated that the NGO has since been blacklisted and steps have been taken for giving compensation to some of the women who had developed complications during the surgeries.

36. The blacklisting is confirmed by Respondent No. 4, that is, Kumar Nath Choudhary, Secretary of Jai Ambey Welfare Society who filed an affidavit on 14th January 2013 in which it is stated that hue and cry was made about the sterilization camp by anti-social elements and as a result three FIRs, namely, Kursakanta P.S. Case No. 03/2012, Case No. 05/2012 and Case No. 14/2012 have been lodged against the NGO.

37. Two charge-sheets have been filed in respect of Kursakanta P.S. Case No. 03/2012 and Case No. 05/2012.

38. As regards Kursakanta P.S. Case No. 03/2012, Charge Sheet bearing No. 23 of 2012 dated 09.03.2012 and supplementary Charge Sheet No. 167 of 2012 dated 31.12.2012 have been submitted. Cognizance of the offence has been taken and thereafter Revision Application No. 44/369/12 has apparently been filed by the accused persons and that is pending in the District Court in Araria.

39. As regards Kursakanta P.S. Case No. 05/2012, Charge Sheet No. 24 of 2012 dated 12.03.2012 and supplementary Charge Sheet No. 87 of 2013 have been submitted. Cognizance of the offence has been taken on 28.06.2012 and a Revision Petition has apparently been filed by the accused bearing No. 31/226/13 which is pending in the District Court in Araria.

40. As regards Kursakanta P.S. Case No. 14/2012 is concerned, the details are not available on record.

41. We have also been told that an FIR has been filed against the NGO Jay Ambey Welfare Society for distributing expired medicines to the beneficiaries of the Family Planning camp held on 7th January 2012. A Charge Sheet has been filed in this regard and cognizance of this offence has also been taken by the Trial Court, but again the details are not available.

42. It is also admitted by the State of Bihar that inquiries into the events that took place on 7th January 2012 have been concluded and show cause notices have been issued to the Medical Officer in charge in the Primary Health Centre in Bausa, Purnia as well as Kursakanta, Araria and also to the Civil Surgeon, Purnia.

43. That the situation in Bihar has not improved is clear from the fact that in Saran district the accreditation of Gunjan Maternity and Surgical Clinic at Chhapra to conduct sterilization procedures was cancelled on 4th March 2012, just a few months after the incident in Araria district.

Affidavit filed by the State of Kerala

44. The State of Kerala has filed a Statement of Facts through a letter dated 15th March 2013. The Statement of Facts is not accompanied by an affidavit and the first page of the Statement of Facts is not on the record of this case. However, the letter states, inter alia, that «In Kerala sterilization camps are conducted only in well equipped centres (usually in first referral units and above hospitals) where there are operation theatre facility, lab facility, referral facility are in place.» It is also stated that «sterilization procedures are carried out in hygienic, well equipped hospitals under the control and supervision of qualified empanelled doctors.» This is reiterated in an affidavit dated 1st July 2013 filed by the State of Kerala.

45. In response to the submission made in the writ petition, the State of Kerala states in paragraph 11 of its affidavit:

[The] tribal population of Kerala State is accorded special consideration for its dealing members. There is no compulsion of promotion of sterilization as part of Government policy. At the same time family planning services are not denied to this segment of the population if demanded. Felt need of the community is assessed by the Health Worker and various options are put before them explaining the merits and demerits of each method and encouraging making right choice.

There is therefore no specific denial of the submission made by Devika Biswas in her writ petition.

Affidavit filed by the State of Madhya Pradesh

46. The State of Madhya Pradesh has filed only one affidavit dated 7th August 2013 and the allegations made by Devika Biswas have not been denied in that affidavit.

47. However, the State of Madhya Pradesh denies coercive sterilizations and asserts that sterilization is undertaken only after informed consent of the patient. The State further submits:

The State Government has issued instructions for taking due precautions for sterilization operations. The State Government has formed Quality Assurance Committee in each District of the State which is headed by the Chief Medical and Health Officer of the district. The function of the Quality Assurance Committee is to review all types of cases where there is some complication and take necessary steps to rectify the same.

There is no specific denial of the events in Balaghat district.

Affidavit filed by the State of Maharashtra

48. The State of Maharashtra has filed only one affidavit dated 14th August 2012 in which it is generally stated that the family planning program is being conducted satisfactorily and a large number of statistics have been given in support of this submission. However, with regard to the sterilization camp held in Nagpur, Chandrapur and Gadchiroli districts it is stated as follows:

It is respectfully submitted that in the light of facts submitted in the Petition by the Petitioner, detailed report has been called from the Civil Surgeon, Gadchiroli, Chandrapur and Nagpur District which is marked and annexed as Annexure-1. However, keeping in view the gravity of such instances reported, State has taken immediate corrective action and instructions have already been issued to all the District Health Officers and Civil Surgeons to perform the family planning operations as per the standards prescribed by Govt. of India in hygienic conditions.

No detailed report has been annexed and no further affidavit was filed by the State of Maharashtra regarding any action taken against any officer responsible for the mishap, any compensation paid or any further action taken in this regard.

Affidavit filed by the State of Rajasthan

49. The State of Rajasthan in its affidavit filed on 23rd November 2012 does not specifically contradict the contents of the report relating to the sterilization procedures carried out in Bundi district but only affirms that the standard operating procedures are being followed and that the failure rate is in conformity with the failure rate prescribed by the Government of India.

50. The State of Rajasthan maintains that the proposed patients are sufficiently instructed and advised with respect to both the sterilization itself as well as post-sterilization care. The State further mentions that continuous efforts are made by the health employees “to motivate females to take up sterilization surgery”. The failure rate at Bundi district “is in conformity to the failure rate prescribed by the Government of India”. The State submits that sufficient steps have been taken for implementation of the directions in *Ramakant Rai (I)* as well as the guidelines of the Government of India.

Affidavits filed by the State of Chhattisgarh

51. The State of Chhattisgarh has taken up the issue of mismanagement of the sterilization camps in Bilaspur district with due promptitude and seriousness and has filed detailed affidavits that not only specify the ameliorative steps taken but also the preventive steps against recurrence of a similar tragedy.

52. Chhattisgarh has confirmed that sterilization camps were organized in Sakri village of Bilaspur district on 8th November 2014 and in Gorela, Pendra and Marwahi in Bilaspur district on 10th November 2014. In all 137 operations were conducted and many of those operated upon complained of vomiting, pain and difficulty in breathing. Consequently, all of them were admitted in nearby hospitals for treatment. Unfortunately, 13 deaths took place despite relief measures including bringing in a team of doctors from the All India Institute of Medical Sciences in New Delhi.

53. Apart from these 137 persons, 37 persons who were not operated upon also had similar complaints and 5 (five) of them died thereby bringing the total number of deaths to 18. It appears that the cause of death of these 5 (five) persons was not related to the sterilization procedure but was due to consumption of Ciprocin 500 tablet.

54. By way of monetary compensation, the State Government has given Rs. 4 lakhs to the families of those who died and Rs. 50,000/- to those who were discharged from medical institutions. The children of the deceased have been adopted by the State Government

which has taken the responsibility of providing them free education and health care till they are 18 years of age. The State Government has also put in an amount of Rs. 3 lakh in a fixed deposit for children of the persons who died in the tragedy. The children would be entitled to the amount on attaining the age of 18 years.

55. Departmental action has been taken against the doctors involved in the sterilization camps. Two of them have been dismissed from service while two others have been suspended pending a departmental enquiry. The Licensing Authority has also been suspended.

56. A Judicial Commission of Inquiry headed by a retired District Judge Ms. Anita Jha was set up to give its findings on the criminal culpability and accountability of the persons concerned. The report given by the Ms. Anita Jha Commission has been accepted by the State Government and also acted upon.

57. Criminal proceedings in the form of Charge Sheet No. 19/2015 dated 15th February 2015 has been filed in the Court of Judicial Magistrate, First Class at Bilaspur against Dr. R.K. Gupta, Ramesh Mahawar, Sumit Mahawar (manufacturers of Ciprocin 500 tablets), Rajesh Khare, Rakesh Khare and Manish Khare (suppliers of Ciprocin 500 tablets). Rakesh Khare and Manish Khare have since been declared proclaimed offenders and their property attached and a reward for their arrest and information of their whereabouts has also been announced.

58. As regards measures taken to prevent the recurrence of such an incident, Chhattisgarh has begun placing greater emphasis on spacing measures which will be more effective in population control. Greater emphasis is being placed on vasectomy for gender equity. An advisory has been issued that Ciprocin 500 should not be consumed and efforts are being made to educate people about the importance, benefits, methods and availability of services in health facilities. A mass awareness campaign has also been launched and several other pro-active measures have been taken.

59. All in all, the State of Chhattisgarh has reacted positively to the tragedy and has not sought to hide inconvenient facts under the carpet.

Further submissions of Devika Biswas

60. Devika Biswas has pointed out in various affidavits filed during the pendency of this writ petition that the campaign for sterilization is effectively a relentless campaign for female sterilization. The web portal of the Ministry of Health and Family Welfare of the Government of India provides statistics on the number of sterilization procedures conducted

in the country for 2012-13. The portal indicates that 97.4% of all sterilization procedures during this period were of women.¹ Devika Biswas alleges that the entire family planning program of Chhattisgarh focuses on female sterilization and the National Health Mission Project Implementation Plan sets targets for female sterilization and allocates 85% of the family planning budget exclusively to female sterilization.

61. More or less confirming the allegations made by Devika Biswas, the affidavits filed by Madhya Pradesh, erstwhile Andhra Pradesh and Goa reflect the fact that the over-whelming number of sterilization procedures is targeted towards women and there is virtually no attention paid to male sterilization.

62. Devika Biswas has also pointed out that data released by the Ministry of Health and Family Welfare during the period 2010-13 shows that at least 363 people have died as a result of sterilization procedures, a very large number of such procedures have failed and that there have been severe complications in respect of several persons who underwent a sterilization procedure. This has resulted in payment of compensation of at least Rs. 50 crores.²

63. The principal problem pointed out by Devika Biswas is with regard to the implementation of the various processes and guidelines issued by the Government of India from time to time. Mere issuance of guidelines by the Government of India does not guarantee their implementation. It is pointed out (for example) that the list of empanelled doctors is not readily available; consent forms are not available in the local language except in the Union Territory of Puducherry; unrealistic targets have been set for sterilization procedures with the result that non-consensual and forced sterilizations are taking place, including of persons who are physically or mentally challenged. Some young persons have been sterilized to meet targets and by and large illiterate persons are sterilized. Devika Biswas is opposed to setting of targets and says that she has the support of the Government of India in this regard, but unfortunately State Governments and Union Territories are still setting informal targets for sterilization.

64. It is further pointed out that there is inadequate monitoring of sterilization camps and facilities. There is little or no monitoring in most camps and health centres, accountability measures are not in place and the rights of thousands of women who undergo sterilization procedures are violated. It is not enough for the Government of India to show that it is merely playing a supportive and facilitative role since the campaign is a national campaign and if it is not properly implemented, it merely leads to passing the buck with the State Government blaming the Government of India and vice versa.

65. The strengthening of the Quality Assurance Committees (QAC) and the District Quality Assurance Committees (DQAC) is crucial to the success of a family planning program of which sterilization procedures is one of the elements. Details of the constitution of QACs and DQACs are not available on the website of the Ministry of Health and Family Welfare. There is also no indication of the steps and decisions taken by them or the minutes of their meetings or reports submitted by them. In other words, vital information is simply not available. Devika Biswas doubts whether these Committees meet on a regular basis although it would be appropriate for them to have at least quarterly meetings if not meetings every six months.

66. According to her, unless these existing institutions function effectively and efficiently or are made to function effectively and efficiently, it is very unlikely that any meaningful progress will be made in the family planning program of the Government of India, of which sterilization is an important component.

67. With regard to the Family Planning Indemnity Scheme, it is pointed out that regular reviews are not carried out; the utilization of funds made available under the Scheme are mere figures since the details of disbursements in case of death, failure, complication etc. are simply not available anywhere. There is no indication of the number of claims filed, the number of claims rejected and the reasons for the rejection and the amount provided to each successful claimant. The Scheme requires a death audit to be carried out but that is more or less missing in every instance. It is stated that specialists who are conversant with the Scheme are not available at sterilization camps and health centers to explain the Scheme in detail so that there is no difficulty or complication faced in the event of an unfortunate mishap. It should be the duty of such a specialist to ensure that each person proceeding to undergo a sterilization procedure has a copy of all the required documents so that there is no difficulty faced later on. This will also ensure that each person gives an informed consent to the sterilization procedure in a language that he or she understands. In fact, all information that is disseminated with regard to the sterilization procedure should be made available in the local language at all Government health facilities and accredited private facilities.

68. It is high time, according to Devika Biswas, for the Government of India to look at the quality of care made available to persons post a sterilization procedure. As is clear from various documents on record including the Ms. Anita Jha Commission Report, after-care facilities in terms of counseling, assistance, follow-up etc. are totally absent.

Is it a public health issue?

69. The fundamental error that the Union of India is making (and it has repeated that in its affidavits) is by asserting that the effective implementation of the sterilization program is the concern of each State since it is a “Public health” issue covered by Entry 6 of List II in the Seventh Schedule (the State List) of the Constitution. Apart from the fact that the various entries in the Seventh Schedule relate to legislative power, the error made by the Union of India is in completely overlooking the more appropriate Entry in the Concurrent List that is Entry 20A which is “Population Control and Family Planning”. This was inserted by the Constitution (Forty-second) Amendment Act, 1976. If the sterilization program is intended for population control and family planning (which it undoubtedly is) there is no earthly reason why the Union of India should refer to and rely on Entry 6 of the State List and ignore Entry 20A of the Concurrent List. Population control and family planning has been and is a national campaign over the last so many decades. Therefore, the responsibility for the success or failure of the population control and family planning program (of which sterilization procedure is an integral part) must rest squarely on the shoulders of the Union of India. It is for this reason that the Union of India has been taking so much interest in promoting it and has spent huge amounts over the years in encouraging it. It is rather unfortunate that the Union of India is now treating the sterilization program as a Public Health issue and making it the concern of the State Government. This is simply not permissible and appears to be a case of passing the buck.

70. As regards Entry 20A of the Concurrent List, the Justice Sarkaria Commission had this to say in Chapter II titled Legislative Relations in paragraph 2.21.08:

Only one State Government has suggested that this Entry should be transferred to the State List. According to them family planning facilities should be an integral part of the health facilities which is a State subject and the present dichotomy between the two facilities hampers their adequate integration. Population control and family planning are a vital part of the national effort at development. This Entry was inserted by the Forty-second Amendment to the Constitution recognizing the importance of this matter. It is well known that a significant part of the fruits of development is neutralized by the high growth in population. With more mouths to feed, less savings are available for development. Large addition to the population has its impact on every aspect of the nation’s life. Many of the ills of the society can be traced back to large numbers who are unable to find a rewarding employment. It is necessary to recognize this inter-dependence between family planning and other sectors. We are, therefore, of the view that Population Control and

Family Planning is a matter of national importance and of common concern of the Union and the States. Notwithstanding the view of that one State Government, the Union of India did not transfer Entry 20A to the State List, thereby making its intentions quite clear and obvious.

71. When the Union of India formulates schemes of national importance such as family planning, their implementation is undoubtedly dependent on the State Governments since they have the requisite mechanism for implementing the schemes and can also take into account the needs that are particular to the State and its people. In this manner, the cooperation of the Union of India and all State Governments is indispensable to the success of such national programs. Adverting to the provisions of the Constitution that allow for such coordination between the Union and States, the Justice Sarkaria Commission held that these provisions are not repugnant to but instead further the principle of federalism.

72. In the same manner, it is imperative for both the Union of India and the State Governments to implement schemes announced by the Union of India in a manner that respects the fundamental rights of the beneficiaries of the scheme. Given the structure of cooperative federalism, the Union of India cannot confine its obligation to mere enactment of a scheme without ensuring its realization and implementation.

73. Apart from anything else, by not giving the sterilization program the importance it deserves (apart from other methods of population control and family planning) and trying to pass the buck to the State Governments, the Union of India is attempting to find an excuse for failure in its duty of effectively monitoring a program of national importance. This game of passing the parcel and treating a national program as a public health issue has to stop and somebody must take ownership of the Population Control and Family Planning program.

Draft National Health Policy

74. To compound the problem and it is much more than a pity, our country does not seem to have any health policy. The draft of a National Health Policy, 2015 was put up on the website on the Ministry of Health and Family Welfare of the Government of India in December 2014 for comments, suggestions and feedback but even after more than one and a half years, the website of the said Ministry shows that the National Health Policy has not been finalized.

75. The draft National Health Policy states that its primary aim is to “...inform, clarify, strengthen and prioritize the role of the Government in shaping health system in all its dimensions...” The draft recognizes the correlation between health and development and also recognizes the high inequity in access to health care.

76. With respect to sterilization, it states that sterilization related deaths are a direct consequence of poor health care quality and is a preventable tragedy. It also recognizes that female sterilizations are safest if performed in an operation theatre which is functional throughout the year and by a professional team with support systems which are in constant use. Camp mode for such operations itself becomes a reason for unsatisfactory quality. More monetary and human resource investment is required for the National Rural Health Mission.

77. Increase in the proportion of male sterilization in the total sterilizations from the existing 5% to at least 30% is stated to be another policy imperative under the health policy. Coercive methods are not justified and are not even effective in meeting the goals of population control. Improved access, education and empowerment should be the aim.

78. Under the head of ‘Governance’ the draft National Health Policy states:

One of the most important strengths and at the same time challenges of governance in health is the distribution of responsibility and accountability between the Center and the States. Though health is a State subject, the Center has accountability to Parliament for central funding-which is about 36% of all public health expenditure and in some states over 50%. Further it has its obligations under a number of international conventions and treaties that it is a party to. Further, disease control and family planning are in the Concurrent list and these could be defined widely. Finally though State ownership has been used by some states to become domain leaders and march ahead setting the example for others, the Center has a responsibility to correct uneven development and provide more resources where vulnerability is more.

Surely, someone should be concerned that we do not have a national health policy or is it that we do not need a national health policy and ad hoc measures are good enough?

Female versus male sterilization

79. A perusal of the various affidavits on record indicates that the sterilization program is virtually a relentless campaign for female sterilization. This is more or less confirmed from

the figures available on the website of the Ministry of Health and Family Welfare of the Government of India which indicate the following:

YEAR	2013	2014
Female sterilizations	1,57,431	1,49,262
Male sterilizations	8130	5085
Total Female sterilizations	1,65,561	1,54,347
% Female Female sterilizations	95.09%	96.7%
% Male Female sterilizations	4.91%	3.29%

80. The issue of male versus female sterilizations was debated and discussed during the course of the hearings and it was conceded by all the learned Counsel that the sterilization program cannot be targeted primarily towards women but must also actively include the sterilization of men as well. It appears to us, without going into the merits and demerits of the incentives given for undergoing the sterilization procedure, the documents on record indicate that the incentive given to males for undergoing a sterilization procedure is less than it is for females and that may perhaps be one of the reasons why the percentage of males being sterilized is so remarkably low as compared to females. This is an area that the Union of India must address itself to, if nothing else then at least for reasons of gender equity.

Right to life

81. The manner in which sterilization procedures have reportedly been carried out endanger two important components of the right to life Under Article 21 of the Constitution-the right to health and the reproductive rights of a person.

(i) Right to health

82. It is well established that the right to life Under Article 21 of the Constitution includes the right to lead a dignified and meaningful life and the right to health is an integral facet of this right. In *C.E.S.C. Limited and Ors. v. Subhash Chandra Bose and Ors.* MANU/SC/0466/1992 : (1992)1 SCC 441 dealing with the right to health of workers, it was noted that the right to health must be considered an aspect of social justice informed by not only Article 21 of the Constitution, but also the Directive Principles of State Policy and international covenants to which India is a party. Similarly, the bare minimum obligations of the State to ensure the preservation of the right to life and health were enunciated

in *Paschim Banga Khet Mazdoor Samity v. State of W.B.* MANU/SC/0611/1996 : (1996) 4 SCC 37.

83. In *Bandhua Mukti Morcha v. Union of India and Ors.* MANU/SC/0051/1983 : (1984) 3 SCC 161 this Court underlined the obligation of the State to ensure that the fundamental rights of weaker Sections of society are not exploited owing to their position in society.

84. That the right to health is an integral part of the right to life does not need any repetition.

(ii) Right to reproductive health

85. Over time, there has been recognition of the need to respect and protect the reproductive rights and reproductive health of a person. Reproductive health has been defined as “the capability to reproduce and the freedom to make informed, free and responsible decisions. It also includes access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free and responsible decisions about their reproductive behaviour.”³ The Committee on Economic, Social and Cultural Rights in General Comment No. 22 on the Right to Sexual and Reproductive Health. Under Article 12 of the International Covenant on Economic, Social and Cultural Rights⁴ observed that «The right to sexual and reproductive health is an integral part of the right of everyone to the highest attainable physical and mental health.»⁵

86. This Court recognized reproductive rights as an aspect of personal liberty Under Article 21 of the Constitution in *Suchita Srivastava v. Chandigarh Administration* MANU/SC/1580/2009 : (2009) 9 SCC 1. The freedom to exercise these reproductive rights would include the right to make a choice regarding sterilization on the basis of informed consent and free from any form of coercion. The issue of informed consent in respect of sterilization programs was considered by the Committee on the Elimination of Discrimination Against Women in *A.S. v. Hungary*⁶, where the Committee found Hungary to have violated Articles 10(h), 12 and 16, paragraph 1(e) of the Convention on the Elimination of Discrimination Against Women⁷ by performing a sterilization operation on A.S. while she was brought in for a caesarean by making her sign a consent form that she did not fully understand. The Committee found that it was not plausible to hold that, in the brief period of 17 minutes commencing from her admission in the hospital to the completion of the surgical procedures, that the hospital personnel provided her with sufficient counselling and information about sterilization, as well as alternatives, risks and benefits, to ensure that she could make a well-considered and voluntary decision to be sterilized. The Committee held:

Compulsory sterilization... adversely affects women's physical and mental health, and infringes the right of women to decide on the number and spacing of their children." The sterilization surgery was performed on the author without her full and informed consent and must be considered to have permanently deprived her of her natural reproductive capacity.

87. It is necessary to re-consider the impact that policies such as the setting of informal targets and provision of incentives by the Government can have on the reproductive freedoms of the most vulnerable groups of society whose economic and social conditions leave them with no meaningful choice in the matter and also render them the easiest targets of coercion. The cases of Paschim Banga Khet Mazdoor Samity and Bandhua Mukti Morcha have emphasized that the State's obligation in respect of fundamental rights must extend to ensuring that the rights of the weaker Sections of the community are not exploited by virtue of their position. Thus, the policies of the Government must not mirror the systemic discrimination prevalent in society but must be aimed at remedying this discrimination and ensuring substantive equality. In this regard, it is necessary that the policies and incentive schemes are made gender neutral and the unnecessary focus on female sterilization is discontinued.

Supplementary directions

88. On the basis of the submissions before us, we have highlighted some key issues that need active consideration. In addition, our attention was repeatedly drawn to the guidelines given by this Court in *Ramakant Rai (I)* and while it is generally the case of the Union of India and all the States that the guidelines are being followed, we find that at least in respect of some of them, there is still much more that needs to be done for their effective implementation not only in letter but also in spirit. Some fine-tuning is also necessary in view of the passage of time, change in circumstances and the need to use technology to the optimum. Accordingly, we find it necessary to issue the following supplementary directions:

1. The State-wise, district-wise or region-wise panel of doctors approved for carrying out the sterilization procedure, must be accessible through the website of the Ministry of Health and Family Welfare of the Government of India as well the corresponding Ministry or Department of each State Government and each Union Territory. The list should contain all necessary particulars of each doctor and not merely the name and designation. This exercise should be completed on or before 31st December, 2016 and thereafter the list be updated every quarter that is by 31st March, 30th June, 30th September and 31st December of every year.

2. The contents of the checklist prepared pursuant to the directions given in *Ramakant Rai (I)* should be explained to the proposed patient in a language that he or she understands and the proposed patient should also be explained the impact and consequences of the sterilization procedure. This can be achieved by (a) ensuring that the checklist is in the local language of the State; (b) it should contain a certificate duly signed by the concerned doctor that the proposed patient has been explained the contents of the checklist and has understood its contents as well as the impact and consequences of the sterilization procedure; (c) in addition to the certificate given by the doctor, the checklist must also contain a certificate given by a trained counselor (who may or may not be an ASHA worker) to the same effect as the certificate given by the doctor. This will ensure that the proposed patient has given an informed consent for undergoing the sterilization procedure and not an incentivized consent.

Sufficient breathing time of about an hour or so should be given to a proposed patient so that in the event he or she has a second thought, time is available for a change of mind.

The checklist prepared pursuant to the direction given in *Ramakant Rai (I)* with the aforesaid modifications should be prepared in the local or regional language on or before 31st December, 2016.

3. The Quality Assurance Committee (QAC) as well as the District Quality Assurance Committee (DQAC) has been set up in every State and District in terms of the directions given in *Ramakant Rai (I)*. However, it is only the designation of its members that has been made available. The details and necessary particulars of each member of the QAC and DQAC should be accessible from the website of the Ministry of Health and Family Welfare of the Government of India as well the corresponding Ministry or Department of each State Government and each Union Territory on or before 31st December, 2016 and thereafter updated every quarter.

4. In addition to the six monthly reports required to be published by the QAC containing of the number of persons sterilized as well as the number of deaths or complications arising out of the sterilization procedure, as already directed in *Ramakant Rai (I)*, the QAC must publish an Annual Report (on the website of the Ministry of Health and Family Welfare of the Government of India as well the corresponding Ministry or Department of each State Government and each Union Territory) containing not only the statistical information as earlier directed, but also non-statistical information in the form of a report card indicating the meetings held, decisions taken, work done and the achievements of the year etc. This will have a significant monitoring and supervisory impact on the sterilization program and

will also ensure the active involvement of all the members of the QAC and the DQAC.

The first such Annual Report covering the calendar year 2016 should be published on the websites mentioned above on or before 31st March, 2017.

5. As many as 363 deaths have taken place due to sterilization procedures during 2010-2013. This is a high figure. During this period, more than Rs. 50 crores has been disbursed towards compensation in cases of death. Apart from steps taken by Bihar and Chhattisgarh during the pendency of the writ petition to mitigate the sufferings of the patients, we have not been told of any death audit conducted by any State Government or Union Territory in respect of any patient, nor have we been informed of any steps taken against any doctor or anybody else involved in the sterilization procedure that has resulted in the death of a patient or any failure or any other complication connected with the sterilization procedure. There is a need for transparency coupled with accountability and the death of a patient should not be treated as a one-off aberration. Therefore, it is directed that the Annual Report prepared by the QAC must indicate the details of all inquiries held and remedial steps taken.

6. With regard to the implementation of the Family Planning Indemnity Scheme (FPIS), there does not seem to be any definitive information with regard to the number of claims filed, the claims accepted and in which category (death, failure, complication etc.), claims pending (and since when) and claims rejected and the reasons for rejection. The QAC is directed to include this information in the Annual Report and the Ministry of Health and Family Welfare of the Government of India as well as the State Governments should make this information accessible on the website, including the quantum of compensation paid under each category and to the number of persons.

We have mentioned above that the learned Solicitor General had assured us on 20th March, 2015 that full details of the funds utilized under the FPIS would be furnished but that information has not been given as yet, necessitating the direction that we have passed.

In addition to the direction relating to the FPIS, the Ministry of Health and Family Welfare should conduct an audit to ensure that the funds given by the Government of India have been utilized for the purpose for which they were given for the period from 2013-14 onwards.

7. The quantum of compensation fixed under the Family Planning Indemnity Scheme (FPIS) deserves to be increased substantially and the burden thereof must be equally shared by the Government of India and the State Government. The State of Chhattisgarh has

shown the way in this regard and it would be appropriate if others follow the lead. Every death or failure or complication related to the sterilization procedure is a set-back not only to the patient and his or her family but also in the implementation of the national campaign. We decline to fix the quantum of compensation but would suggest, following the example of the State of Chhattisgarh, that the amount should be doubled and shared equally.

8. The Union of India is directed to persuade the State Governments to halt the system of holding sterilization camps as has been done by at least four States across the country. In any event, the Union of India should adhere to its view that sterilization camps will be stopped within a period of three years. In our opinion, this will necessitate simultaneous strengthening of the Primary Health Care centre's across the country both in terms of infrastructure and otherwise so that health care is made available to all persons. The significance of having well equipped Primary Health Centers across the country certainly cannot be over-emphasized. Therefore, we direct the Union of India to pay attention to this as well, since it is absolutely important that all citizens of our country have access to primary health care.

9. The Union of India should make efforts to ensure that sterilization camps are discontinued as early as possible but in any case within the time frame already fixed and adverted to above. The Union of India and the State Governments must simultaneously ensure that Primary Health Centers are strengthened

10. Although the Union of India has stated that no targets have been fixed for the implementation of the sterilization program, it appears that there is an informal system of fixing targets. We leave it to the good sense of the each State Government and Union Territory to ensure that such targets are not fixed so that health workers and others do not compel persons to undergo what would amount to a forced or non-consensual sterilization merely to achieve the target.

11. The decisions taken in the high level meetings held on 15th May 2015 and 17th November 2015 as well as the National Summit on Family Planning held on 5th and 6th April 2016 should be scrupulously implemented by the Ministry of Health and Family Welfare of the Government of India. The said Ministry should also ensure effective implementation of the decisions taken keeping in mind that the sterilization program is a part of a national campaign.

12. The Union of India is directed to ensure strict adherence to the guidelines and standard

operating procedures in the various manuals issued by it. The Sterilization program is not only a Public Health issue but a national campaign for Population Control and Family Planning. The Union of India has overarching responsibility for the success of the campaign and it cannot shift the burden of implementation entirely on the State Governments and Union Territories on the ground that it is only a public health issue. As the Justice Sarkaria Commission put it “Population Control and Family Planning is a matter of national importance and of common concern of the Union and the States.”

13. We are pained to note the extremely casual manner in which some of the States have responded to this public interest petition. What stands out is the response of the States of Madhya Pradesh, Maharashtra, Rajasthan and Kerala in respect of which States allegations were made concerning mismanagement in at least one sterilization camp. None of these States have given any acceptable response to the allegations and we have no option but to assume that the camps that have been referred to in the writ petition were mismanaged as alleged by Devika Biswas. However, the matter should not end here. We direct the Registry of this Court to transmit a copy of this judgment to the Registrar General of the High Court in the States of Madhya Pradesh, Maharashtra, Rajasthan and Kerala for being placed before the Chief Justice of the High Court. We request the Chief Justice to initiate a suo moto public interest petition to consider the allegations made by Devika Biswas in respect of the sterilization camp(s) held in these States (the allegations not having been specifically denied) and any other similar laxity or unfortunate mishap that might be brought to the notice of the Court and pass appropriate orders thereon. We also direct the Registry of this Court to transmit a copy of this judgment to the Registrar General of the Patna High Court for being placed before the Chief Justice of the High Court. We request the Chief Justice to ensure speedy completion of the investigations and proceedings relating to the mishap on 7th January 2012 in the sterilization camp in Kaparfora Government Middle School, Kursakanta, Araria district as well as the mishap in Chhapra in Saran district that led to cancellation of the accreditation of Gunjan Maternity and Surgical Clinic on 24th March 2012.

14. The State of Chhattisgarh is directed to implement the recommendations given in the Ms. Anita Jha Report at the earliest and with all sincerity.

15. We have already expressed our sadness at the fact that the National Health Policy has not yet been finalized despite the passage of more than one and a half years. We direct the Union of India to take a decision on or before 31st December, 2016 on whether it would like to frame a National Health Policy or not. In case the Union of India thinks

it worthwhile to have a National Health Policy, it should take steps to announce it at the earliest and keep issues of gender equity in mind as well.

3. Manju Devi vs State of Madhya Pradesh W.P. (C) 17358/ 2018

Synopsis

In violation of the petitioner fundamental right to like, to health to equality, and to dignity, petitioner got married to Santosh Balmik. After few years of marriage petitioner became pregnant and delivered child, thereafter she again became pregnant and delivered child. After delivered 1 baby girl and 4 baby boy and then petitioner and her husband decided for Family Planning and she was admitted before Community Health Center at Mehgaon on dated 19.12.2016 and sterilization operation was conducted by the respondents. Petitioner was not informed about the risk of failure neither any of the health worker went to check-up Smt. Meera Health. Due to lack of information both Smt. Meera and her husband that there was no chance of pregnancy. After few months passing of family planning then husband and wife started cohabitation each other then the petitioner felt that her menstruate was not cycling properly then she informed her husband and both decided to visit nearest community health center, Mehgaon, District Bhind then doctor told her that it is required to urine test and other formalities so that petitioner did it as per doctor instruction then doctor gave the opinion that she became pregnant. With respect to second pregnancy in this respect petitioner was admitted in hospital on dated 12.09.2018 and delivered a baby girl child on dated 13.09.2018 and discharge baby and mother on dated 15.09.2018. After getting baby then petitioner informed concerning authority with respect to failure of sterilization as well as family planning on dated 29.11.2018 before Chief Medical & Helath Officer at Bhind as well as District Collector Bhind and also submitted written application with respect to compensation. After then no compensation was given till date to the petitioner then petitioner also approached to the concerning authority with telephonic as well as personnel appearance, but due to only promise that compensation amount would be pay as soon as possible and also said to the petitioner that your application is under process. After this incident the petitioner again submitted written application in person in the year of 2019 alongwith other document are annexed. But till date no compensation amount is given by the respondent so that this writ petition is being filed by the petitioner.

Facts

On 19.12.2016, petitioner underwent a sterilization procedure at Community Health Center, Mehgaon, District Bhind. The petitioner did not receive any counseled prior to her sterilization, nor did she receive information about the Family Planning Indemnity Scheme, even you did not tell her the procedure and claim scheme on failure of sterilization.

The petitioner is illiterate she does not know to read or write either in English or Hindi but only know to thump impression. Petitioner did thump impression a consent form. however, petitioner does not speak or read English. No one translated the content of the form. Furthermore, no one counseled petitioner on the procedure, post-surgery care, or the possibility of failure and available compensation. The petitioner got married to Santosh Balmik at the age of 20 years. She had delivered children continuously from her marriage. And the couple decided to under to sterilization to constrain in upbringing children the Respondents failed to ensure adequate access to quality Family Planning services in Community Health Center Mehgaon, District Bhind (M.P.) and conducted sterilization camp and petitioner was got her sterilization done. Petitioner and her husband got back to their village on their own expenses as no transport facilities were provided to them by the CHC. Sterilization procedure occurred on 19.12.2016. After her sterilization about few months of sterilization petitioner came to know that her menstruate cycle is not getting then she went to Health Center discussed with concerning doctors and she came to know that her sterilization got failed and she is pregnant. She was given information by the doctor.

After receiving the information about the pregnancy then petitioner was diagnosed with respect to pregnancy medical measurement and other test in this respect petitioner was admitted for baby had community Health Center, Mehgaon. Then she delivered a female baby child on dated 12.09.2018. During admitted in hospital for delivery petitioner had also submitted Family Ration Card alongwith Voter Card as well as Aadhar Card. The failure of petitioner's sterilization procedure entitles petitioner to Rs. 30,000/- as per Section N of the Family Planning Indemnity Scheme, 2013.

As a result of the Supreme Court ruling in **Ramakant Rai**, the Government of India introduced the Family Planning Insurance Scheme (FPIS), which became the Family Planning Indemnity Scheme in 2013. This scheme combines incentive payments for any acceptor of sterilization, which have been in place since 1981, with a new compensation for complications scheme. (**Ramakant Rai & ANR. petitioner(s) Vs. Union of India & Others order dated 01.03.2005 Writ Petition (Civil No. 209/2003).**)

The Respondents have failed to address the systematic causes of petitioner case: inadequate infrastructure, a failed referral system, insufficient staff, and poor implementation of government schemes. The Government of India has created schemes to encourage women and men accept sterilization as method of family planning. Through the National health Mission (NHM), the Government coordinates Family Planning Indemnity Scheme - FPIS, a financial incentive scheme to encourage women and men for sterilization. In **Ramakant Rai Vs. Union of India (W.P.(C) 2009/2003)**. Judgment to ensure quality of care in sterilization and to compensate for adverse outcome following provisions were made :

- Standard Operating Procedures were laid down.
- Quality Assurance Committees at State and District level were constituted.
- Standard consent form created.
- Family planning Insurance Scheme which became the Family Planning Indemnity Scheme in 2013. But, in many cases, the range and quality of services in the facility has been seriously neglected.

In our co-ordinate bench Indore has decided similar nature of petition and directed state authority to pay the compensation to the petitioner as per guidelines of Government of India when petitioner sterilization was failure. And this matter is decided in WP No. 3634/2016 and order was passed on dated 05.07.2017. As far as the family planning indemnity scheme was published 2013 by the Government of India Ministry of Health and Family Welfare in which described parameters with regard to family planning Insurance Scheme as well as failure of sterilization as well as other compensation on other head and said guidelines has been mentioned manual for Family planning indemnity scheme in the year of 2013.

Order

14th September, 2018

Shri Amin Khan, learned counsel for the petitioner. According to learned counsel for the petitioner, scheme dated 29-05-2018 has been filed which is relevant for present controversy. Heard on admission. Issue notice to the respondents on payment of process fee within seven days by RAD as well as ordinary mode. Notice be made returnable within four weeks. The petition is ongoing.

4. **Prakashi vs State of Rajasthan W.P. (C) 6200/ 2018**

Facts

The petitioner and her husband decided to opt for Family Planning methods as they did not want more children due to poor financial condition of the family. So, on dated 1st December, 2015 petitioner had done the process of sterilization at Govt. Community Health Centre, Kudgaon, District Karauli. At the CHC, her sterilization operation was conducted by Dr. Dinesh Gupta and thereafter a Sterilization Certificate with case card no. 23 was issued to the petitioner by the Department of Medical, Health and Family Welfare, Govt. of Rajasthan.

After the sterilization operation, petitioner faced some health related problems and she went to the Govt. hospital Kudgaon where petitioner was informed about her pregnancy. Petitioner was very surprised to know about her pregnancy because after the sterilization operation, she was assured that sterilization operation has been performed successfully and she would never conceive in future but the information of pregnancy was very traumatic to the petitioner and her husband. They petitioner and her husband could not decide what should be done now. The respondent department did not provide any assistance regarding the provisions of Medical Termination of Pregnancy. It is submitted that pregnancy may be terminated by a registered medical practitioner up to the period of twelve weeks and till twenty weeks on the opinion of two doctors as per the provision of **Medical Termination of Pregnancy (Amendment) Act, 2002**.

The petitioner met with the local health workers of respondent department and informed about the failure of her sterilization operation but the local health workers did not provide any assistance with regard to failure of her sterilization as well as providing compensation whereas it is the duty of frontline health workers in guiding and assisting the woman/family in applying for the compensation and completing the claim process. Petitioner did not receive any counselling about the procedure, potential risks or post surgery care from the Respondents which is in clear violation of **Standards of Male and Female Sterilization Services, 2006** laid down by the Ministry of Health and Family Welfare as laid under 1.6.3 of the Guidelines, which has outlines the health facility's obligations:-

“This may be due to either technical deficiency in surgical procedure or spontaneous re-canalization. To detect failure leading to pregnancy at the earliest, the client should be advised

to report to the facility immediately after missed period. The client should be offered MTP and repeat sterilization surgery or should be medically supported throughout the pregnancy if she so wishes”

“All cases of failure and complications, major or minor, arising during surgery or post-surgery must be documented. The complications that required hospitalization and all cases of failure must be reported to the district quality assurance committee. The district quality assurance committee will in turn be responsible for communicating such information to the concerned insurance service providers for compensation.

After the pregnancy petitioner continuously remained on rest and on dated 6/8/2016 she had to deliver a child named Nitesh.

Petitioner had informed to the local health worker about failure of her sterilization operation as well as for compensating her under the Family Planning Indemnity Scheme because she is entitled for compensation for the failure of sterilization as per the government norms laid down under the Family Planning Indemnity Scheme Manual-2013 of the Government of India. State Respondents no.4 viz. District Quality Assurance Committee has failed to comply with its duty as envisaged by the said scheme. Due to the failure of sterilization the petitioner including her family members suffered tremendous physical and mental trauma and economic losses.

The Respondents are responsible for providing basic quality assurance as per the Government guide lines and also in compliance of the Hon’ble Supreme Court directions laid down Ramakant Rai versus Union of India as well as for implementing guidelines and other health-related schemes. The Petitioner was denied of quality services during her female sterilization (tubectomy) operation as per the government norms. Non compliance of standard procedures as per the government norms of quality assurance for sterilizations which has caused failure of sterilization of the petitioner and for which petitioner is entitled to get the mandated claim amount of Rs. 30,000/- (Rupees Thirty thousand) along with the compensation of Rs.2 Lakhs. The slipshod act of the State Respondents caused physical and mental agony to the petitioner and also to her family members.

Men and women have a right of to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights. Article 16(e) of Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) also refers to this provision. This fact

was further strengthened by the International Conference on Population and Development (ICPD) held at Cairo in the year 1994 which stated that-

“All couples and the individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.”

Thus, it is well proved from the above mentioned provisions that not only the Sexual and Reproductive Health Rights of Petitioner has been violated but some provisions under other International treaties like CEDAW and ICPD have also been violated in this case.

1. To ensure the provision of quality services in sterilization, a Quality assurance Manual was prepared in 2006 by the Government of India. The revision of the earlier manual has assumed significance as the Government of India has undertaken several new initiatives, such as the introduction of a family planning insurance scheme for public as well as private providers, accreditation of health facilities and empanelment of doctors for family planning services. As per Section-5 of the Quality Assurance Manual for Sterilization Services drafted by the Research Studies and Standards Division of the Ministry of Health and Family Welfare, Govt. of India a monitoring of sterilization services is done at Central, State and District level through constitution of Quality Assurance Committees. Copy of the Quality Assurance Manual for Sterilization of Services, 2006 will be kept ready at the time of hearing of the case.
2. That the Hon'ble Supreme Court of India in its Order dated 1.3.2005 in Civil Writ Petition No. 209/2003 (Ramakant Rai V/s Union of India) has, *inter alia*, directed the Union of India and States/UTs for ensuring enforcement of Union Government's Guidelines for conducting sterilization procedures and norms for bringing out uniformity with regard to sterilization procedures by –
 1. Creation of panel of doctors/health facilities for conducting sterilization.
 2. Procedures and laying down of criteria for empanelment of doctors for conducting sterilization procedures.
 3. Laying down of checklist to be followed by every doctor for carrying out sterilization procedure.
 4. Laying down of uniform Performa for obtaining of consent of person undergoing sterilization.

5. Setting up of Quality Assurance Committee for ensuring enforcement of pre and postoperative guidelines regarding sterilization procedures.
6. The State shall also bring into effect an Insurance Policy etc., until such time the Union of India has prescribed a standard format.

The above all directions have been taken into consideration and consolidated in the manuals on Standards and Quality Assurance in Sterilization Services under “Family Welfare Activities”. The Family Planning Insurance Scheme is one of the initiatives launched under direction from the Hon’ble Supreme Court w.e.f. from 29th November, 2005, which has been modified as the Family Planning Indemnity Scheme effective from 01.04.2013. The Family Planning Indemnity Scheme is uniformly applicable for all States/UTs. With effect, 01.04.2013, it has been decided that States/UTs would process and make payment of claims to accepters of sterilization in the event of death/failures/complications/ Indemnity cover to doctors/health facilities. It is envisaged that States/UTs would make suitable budget provisions for implementation of the scheme through their respective State/UT Program Implementation Plans (PIPs) under the National Rural Health Mission (NRHM) and the scheme may be renamed “Family Planning Indemnity Scheme”. It will be the responsibility of the District Official designated for the scheme by the State Government to ensure timely filing and processing, including payment of eligible claims. With effect from 1st April 2013, liability in respect of such cases would be met by the State Government/UT Administration from funds released by Government of India, under the National Rural Health Mission (NRHM), through State Programme Implementation Plans (PIPs).

Petitioner was not in condition to bear unwanted pregnancy because she belongs to a poor family, her husband is a daily wager and the monthly income of her family is very low. Due to unwanted pregnancy not only the family of the petitioner faced the financial crisis but also faced physical and mental stress but the respondents have failed to provide mandated claim and compensation amount to the petitioner which is per se illegal, discriminative and violative the Sexual and Reproductive Health Right of the petitioner and such action of the respondents cannot be sustainable in the eyes of law.

It is the duty of the State Government to provide proper health services to women as per the concrete Service Guarantees under the Family Planning Indemnity Scheme, RMNCH+A and other government schemes but here the State Respondents failed to provide 30,000/- (Rupees thirty thousand) along with other incentives for the failure of sterilization to the petitioner as mandate under the above-mentioned schemes and

government norms as also failed to adhere to their constitutional obligations to protect reproductive rights as enshrined in Article 21's right to life, right to live with human dignity, right to health.

Order

9th May, 2018

Two weeks' time is granted to remove the defect(s), failing which the writ petition shall stand dismissed automatically without further reference to the Court.

The petition is ongoing.



5
CHAPTER
Child Marriage

Child marriage has been illegal in India since the 1929 enactment of the Child Marriage Restraint Act. The Prohibition of Child Marriage Act, 2006, now governs the issue of child marriage. Despite its clear illegality, the issue continues to proliferate across the country, heavily concentrated in certain districts and states such as Bihar, Rajasthan, Karnataka, and Tamil Nadu. Although the Act strictly prohibits the practice of child marriage with the punishment of prison sentences, the implementation of the Act is poor, which allows the practice to continue – with community leaders and police officials even being complicit in the practice.

As of now, the Act states that the legal age for girls to get married is 18, which rises to 21 for boys. This stipulation has long been controversial, with people questioning the reasoning for this age gap depending on gender. This compounds the widely recognized fact that child marriage disproportionately affects girls. Additionally, a key section of the Act – Section 16 – which states that all states must appoint Child Marriage Prohibition Officers (CMPOs), has been found to be largely unimplemented. For its recent PIL in the Supreme Court of India on the poor implementation of the Act, HRLN filed RTIs in all states of India to garner data on child marriage and to enquire as to the functionality of the CMPOs. Shockingly, the only state with CMPOs who work full time without any other delegation is Haryana. All other states either had a total absence of CMPOs, or had CMPOs who had simply been delegated the role on top of existing duties – some with duties so far removed from the issue, such as tax officers. This glaring lack of implementation formed a key demand of HRLN’s PIL.

1. Forum for Fact Finding Documentation and Advocacy v. Union of India, Supreme Court W.P. (C) 212/2003

Synopsis

The Forum for Fact Finding Documentation and Advocacy (FFDA), an authority on child marriage, filed a public interest case to address child marriages. Such marriages inevitably lead to girl child servitude, child sexual abuse, and often rape by household members. Moreover, married girls are substantially more likely to suffer maternal death or morbidity because their bodies are not physically ready for pregnancy and childbirth. In addition to this, because girls who are married young have less access to education and less power in the family, they retain less control over the number and spacing of their children. The Court ordered the government to enforce and improve the Child Marriage Restraint Act, 1929, which led to the passage of the Prohibition of Child Marriage Act, 2006. This case has been joined with others addressing child marriage, and is still before the Court.

Facts

Although reform movements pioneered work against child marriage in the past decade, a shocking 26.8% of girls are married before the age of 18 in present-day India, according to the 4th National Family Health Survey conducted in 2015-16. Child marriages are often celebrated on a mass scale in various states, especially on auspicious occasions. In violation of the Child Marriage Restraint Act of 1929, even local government officials and the police sometimes participate in these outlawed practices by accepting bribes of Rs 500 to overlook child marriage ceremonies. The Forum for Fact Finding Documentation and Advocacy (FFDA) is an NGO working to represent the rights of women, children, and other disenfranchised sections of society. In various studies conducted over a number of years, FFDA has documented thousands of illegal child marriages all over India. In traditional communities, child marriages are seen as a tried and tested way of passing on familial property and wealth because early marriages fetch higher bride prices and lower dowries. Child marriages also enforce patriarchy as early marriage keeps girls in the domestic sphere. Poverty and low levels of development also contribute to the scourge. For many poor people marrying off their girl child early is the best way to get rid of an extra mouth to feed.

Child marriage also jeopardizes the reproductive health of girls. Because their bodies

are not fully developed, girls face a higher risk of maternal mortality or morbidity. The leading cause of death for women aged 15-25 in India is maternal death.¹ Due to the greater control exercised by husbands and in-laws over young brides, these girls are less able to exercise control over the number and spacing of their children, seek birth control and contraceptive methods or otherwise control their reproductive health.

Relevant Law

Constitution: Articles 21 (right to a dignified life) & 23 (right to be free from exploitation)

Statutes & Schemes: Child Marriage Restraint Act of 1929

Orders

February 28, 2005

When the matter was called out, learned Additional Solicitor General appearing on behalf of the Union of India produced before us a copy of the Bill known as the Prevention of Child Marriage Bill, 2004. The Bill is said to have been introduced in the Parliament. It is also stated that the objections have been invited from the general public by issuing public notice in this behalf in the News Papers on 28.2.2005 in terms whereof objections may be filed within 15 days there from. We, however, hope and trust that in the meantime the Collectors and SPs of all the Districts in the States shall make endeavour to prevent child marriages as far as possible and preferably in cases where mass marriages take place.

In that view of the matter let the case is called out 8 weeks hence.

May 13, 2005

... While we do not intend to pass any further interim order as prayed for in these applications at this stage, we reiterate that the interim order dated 28th February, 2005 shall continue. We request respective State Human Rights Commissions/State Human Rights Committees constituted in each State to conduct inquiries into the incidences of child marriages which have allegedly taken place. The National Human Right Commission is also requested to coordinate with the respective Human Rights Commissions/State Human Rights Committees in this behalf.

August 24, 2007

Having heard learned Solicitor General and Mr. Colin Gonsalves, learned senior counsel, we are of the opinion that the Prohibition of Child Marriage Act, 2006 (No.6 of 2007) may be brought into force as expeditiously as possible and preferably within four weeks from date.

Subsequent to this petition, the Prohibition of Child Marriage Act, 2006, was enacted across India. Nevertheless, as is a constant factor with regard to legislation in India, good laws are met with incredibly poor implementation, rendering them useless, though their mere presence grants policymakers an opportunity to deflect responsibility for continuing social issues. As is this case in this instance, child marriage continues to be a plague upon Indian society, with NFHS 4 estimating that 26.8% of women were married before the age of 18. Along with this indicator also comes poor indicators relating to the education and schooling of girls. Data relating to child marriage is contradictory and confusing where it does exist. The implementation of the PCMA is incredibly poor. Due to this, **HRLN filed a new petition pertaining to the implementation of the PCMA, with a focus on Section 16, outlined below.**

2. Society for Enlightenment and Voluntary Action and Anr. Vs. Union of India and Ors. Writ Petition (C) 1234/ 2017

Synopsis

This public interest petition was filed to demonstrate that neither the Union of India nor any of the States/UTs have any intention to implement the provisions of the Prohibition of Child Marriage Act, 2006 as a result of which the level of child marriages in India remains approximately at the level it was during independence. It framed child marriage as a violation of a girl's right to life, right to personal liberty (Article 21), right to education (Article 21 A) right to health, and the right to equality and non-discrimination (Articles 14 and 15).

The petition relied on primary qualitative research conducted on the issue of child marriage in the states of Bihar, Odisha, Assam, Uttarakhand, Chhattisgarh and Haryana, as well as secondary desk-research utilizing both Government and international non-governmental organization data.

Facts

Relevant excerpts of the petition include:

‘The population in India is increasing at a rate of 8%. However, the rate of child marriage is decreasing by a mere rate of 1% per year. This is reflective of the States inaction on the issue and is essentially an infective decline, highlighting the lack of enforcement of the Act brought in place with the intent to eradication of child marriage.’

‘Specifically noting the importance of Section 16 of the PCMA which calls for the implementation of Child Marriage Prohibition Officers to both prevent and address child marriage, The Law Commission Report No. 205, on the Proposal to Amend the Prohibition of Child Marriage Act, and other allied laws, 2008, summarized: *“The Act lays emphasis on the prohibition of child marriages by providing for the appointment of Child Marriage Prohibition Officers by the State Governments and gives powers to these Officers to prevent and prosecute solemnization of child marriages and to create awareness on the issue. However without the required financial allocations these Officers in most of the states have not been appointed.”*

‘In order to eradicate child marriage, there needs to be an understanding of the dynamics and complexity of the issue. Some of the deficiencies in the current law are outlined in the report and can be summarized as follows:

- i. The Child Marriage Protection Officers are not adequately equipped, trained and sensitized for dealing with child marriage.
- ii. Enforcement officers are not aware of their roles and responsibilities under the PCMA, 2006 therefore making them ill equipped to prevent child marriages.’

The petition prayed for a range of orders and directions for the Central and State Governments to be obliged to follow. The most pertinent prayers are outlined below:

- a) Issue a writ of mandamus or any other appropriate writ, order or direction to all the Chief Secretaries of the States and the Administrators of the Union Territories as well as the Director Generals of Police to ensure that the Collectors and the Superintendents of Police in all the Districts of India forthwith take active steps to prevent child marriages from taking place in their respective jurisdictions;
- b) For an order directing all the Chief Secretaries of the States and the Administrators of the Union Territories to identify the officials who failed to prevent child marriages in their jurisdictions and to institute departmental proceedings against them and

impose punishment in accordance with law;

- c) For an order directing all States/UTs to appoint exclusive Child Marriage Prohibition Officers under section 16 of The Prohibition of Child Marriage Act, 2006 for every district, and by notification invest these officers with police powers as set out in section 16(3) of the Act, and to display the contact details of such officers on an exclusive child marriage website;
- d) For an order directing all chief secretaries of States and Union Territories to direct their District Magistrates in the state to prevent solemnization of mass child marriages on certain days such as Akshaya Trutiya in accordance with section 13(4) of the Act;
- e) For an order directing chief secretaries of States and Union Territories to direct the Superintendents of Police throughout India to prosecute all such persons, by whatever designation called, who solemnize child marriages;
- f) For an order directing all States and Union Territories to ensure that the Collectors and Superintendents of Police of all the districts in the country, identify all child brides within their jurisdictions and thereafter ensure that the child bride receives entirely at government expense, comprehensive, modern and free of charge education, health services, food and nutrition as well as substantial compensation for herself and her children;
- g) For an order directing all States and Union Territories to disclose on affidavit the number of child marriages taking place district wise, the number of prosecutions and their end results and the number of child marriages prevented.

Relevant Laws

Constitution: Article 21 (Right to Life and Personal Liberty), corresponding Right to Health interpreted into this provision as per case law

Article 21 A (Right to education)

Articles 14 and 15 (Rights to Equality and Non-Discrimination)

Statutes: The Prohibition of Child Marriage Act, 2006

International Conventions: The Convention on the Elimination of Discrimination Against Women (CEDAW)

Outcome

Upon approaching the court with the original petition detailed above, the Supreme Court judges directed HRLN's lawyers to return to the court with more contemporary data regarding the amount of child marriages taking place, as well as the number of CMPOs and their functions. A notable difficulty in this was the fact that there is such a stark lack of clear, reliable data that has been updated in the past few years regarding child marriage. Additionally, Government data and international NGO data often contradict one another.

As a result of this dilemma, HRLN elected to send Right to Information Requests (RTIs) to all states and union territories of India, as well as the Central Government, requesting information on the amount of child marriages that have been reported but not necessarily taken to the police (hence the absence of NCRB data), as well as the number of CMPOs and their functions. The responses varied; many state departments simply transferred the RTIs onto other departments, but the responses that were received were telling. Of note was the fact that it is now evident that the only State in the entirety of India that has CMPOs who function *only* as CMPOs (rather than having additional charges). All other States and UTs had District Collectors, Child Protection Officers – even *tax officers* – working as CMPOs. The duty of the CMPO is therefore relegated to nothing more than an additional charge – hence no wonder the implementation of the PCMA is poor.

In addition to this, we found that despite the highest number of child marriages being registered in a police station in 2016 as per NCRB were in Tamil Nadu (55 cases), Karnataka (51 cases) and West Bengal (41 cases), the State of Tamil Nadu in its RTI response reflected over 1000 instances of child marriage in Chennai alone. This demonstrates a severe disconnect in cases arising and their subsequent reportage to the police, and further demonstrates that CMPOs are not effectively working to refer such cases to the police, which they are inclined to do.

All of the above information was compiled into an additional affidavit, which was then filed as a rejoinder to the original petition in 2018. In July 2018, the Union Government responded to the additional affidavit, expressing concern that child marriage was a continuing practice but noting that it had reduced due to their methods. However, they made no response to the evidence that had clearly arisen through the RTI responses. HRLN is now moving to respond to the claims made by the Central Government.

3. Jago Foundation vs. the Union of India W.P(PIL) No. 5406 of 2013

Synopsis

According to Annual Health Survey 2010-11, Jharkhand ranks third among States witnessing highest number of child marriages in India. Unfortunately, no case of child marriage is registered here under The Prohibition of Child Marriage Act 2006 till date, as per United Nations International Children's Emergency Fund (UNICEF). The fact is a challenging issue as more than 50 per cent cases are prevalent in the State, indicates the data of Annual Health Survey.

Facts

Jharkhand is one the states where child marriage is prevalent and due to the lack of awareness, the people are not sure how to act upon such incidences. Jago Foundation, one of the leading organizations of Jharkhand came forward and became the petitioner. HRLN had filed its first ever case on Child Marriage. It vouched for strengthening of PCM Act of 2006 and its proper implementation. One of the prayer also included appointment of dedicated personnel as Child marriage Prohibition Officers to combat the rising issue. After almost 4 years, the High Court of Jharkhand gave a positive order.

Orders

Dated 10th February, 2016

1. Initially, the writ petition was filed for a direction upon the respondent-State of Jharkhand to appoint a full-time Child Marriage Prohibition Officer under Section 16(1) of the Prohibition of Child Marriage Act, 2006 and for a direction for framing Rules under Section 19 of the Act. During the pendency of the writ petition, the State Government issued notification dated 11.06.2007 designating the Block Development Officer in each Block as the Child Marriage Prohibition Officer and, vide notification dated 23.04.2015, the Jharkhand Child Marriage Prohibition Rules, 2015 have also been notified.

2. Mr. A.K. Agarwal, the learned counsel for the petitioner-Jago Foundation submits that in view of the incognizable steps taken by the State Government for effective implementation of the Prohibition of Child Marriage Act, 2006, detail guidelines may be issued by the Court. Referring to the counter affidavit dated 20.08.2014 filed on behalf of the respondent-State Government, the learned counsel for the petitioner points out that except, organizing a

State Level Consultation on 06.09.2012, the respondent-State has not taken any step in the matter and, in fact, even the details of the aforesaid State Level Consultation have not been brought on record. It is stated that in the last five years, hundreds of child marriages in violation of the prohibition under the 2006 Act have been performed in the State of Jharkhand, however, unmindful of their statutory duty the respondents have not taken proper and effective step in the matter.

3. Without delving deep in the history, we notice that amongst Hindus, child marriage was prevalent in abundance and such marriage was even recognized as valid. The ill-effect of the child marriage was noticed even during the colonial period and there was no mechanism to discourage child marriages. The Child Marriage Restrain Act, 1929 was enacted to restrain child marriages and to carry forward the reformist movement for eradicating the evil of child marriage. However, over a period it was felt that the provisions of 1929 Act should be made more effective and to effectively prevent the evil practice of child marriages in the country, stringent punishment should be provided. The National Commission for Women in its annual report for the year 1995-96 recommended that the Government should appoint the Child Marriage Prevention Officers immediately. The Commission also recommended that, (i) the punishment provided under the Act should be more stringent; (ii) marriages performed in contravention of the Act should be made void; and (iii) the offences under the Act should be made cognizable. The National Human Rights Commission also undertook a comprehensive review of the existing Act and made recommendations for comprehensive amendment in its annual report 2001-02. Accepting the recommendations and after consulting the State Governments and the Union Territories' Administrations, the Central Government repealed the 1929 Act and enacted the Prohibition of Child Marriage Act, 2006.

4. Rule 4 of the "Jharkhand Child Marriage Prohibition Rules, 2015" provides that awareness through different media and incentive for active role played by the members of civil society, PRI and socially concerned citizen are few steps which have to be taken. Rule 4(3) provides that the District Magistrate may pass an order under sub-section (5) of Section 13 of the Act directing all or any police station to keep vigil at religious and public places. The rule also enjoins the District Magistrate to take appropriate action to check and prevent the solemnization of child marriages especially, during special occasions when mass child marriages are solemnized.

5. A report prepared by the United Nations Population Fund (UNPF) discloses that in child marriage the Jharkhand is among the top three States in the country. According to Annual Health Survey of 2010-11, Jharkhand is only behind Bihar and Rajasthan where

51.8% girls below 18 years were married. The National Family and Health Survey-III Report of 2005-06 indicate that 63.2% women in Jharkhand got married before 18 years; the percentage however, fell to 55.7% in 2007-08 Survey-III report.

6. In the aforesaid facts, considering the indifferent response of the respondents-authorities, we hereby issue the following directions:

- (i) State Government shall appoint Child Prohibition Officer for each District for entrusting him with the duties and liabilities under Jharkhand Child Marriage Prohibition Rules, 2015;
- (ii) Child Welfare Committee constituted under Section 27 of the Juvenile Justice (Care & Protection of Child) Act, 2015 for every District shall coordinate with Child Marriage Prohibition Officer for effective implementation of the Prohibition of Child Marriage Act, 2006 and for protecting the best interest of the child;
- (iii) A complete mechanism shall be evolved by District Magistrates of each District of the State for entertaining the complaints and action thereon in terms of Jharkhand Child Marriage Prohibition Rules, 2015;
- (iv) District Magistrate shall pass necessary directions under Sub Section (5) of Section 13 to all the Police Stations falling within his jurisdiction to keep vision at religious and public places and also to take appropriate action to check and prevent the solemnization of child marriages, especially during special occasions when mass child marriages are solemnized;
- (v) Keeping in view the sensitivity of the issue, District Magistrate, in terms of Rule 4 of Jharkhand Child Marriage Prohibition Rules, 2015 shall ensure that awareness through different media is made in this regard involving members of civil society/ PRI and socially concerned citizen by calling them and providing incentive for their active role in bringing the matter to the concerned authority;
- (vi) Jharkhand State Legal Services Authority (for short 'JHALSA') shall also step in and ensure that it reaches out to the masses by organizing awareness camps at different levels involving District Legal Services Authority (DLSA), Taluk Legal Services Authority (TLSA) and the District Administration.

7. Registry is directed to supply a copy of the order to the Member Secretary, JHALSA for perusal by Hon'ble the Executive Chairperson of JHALSA. A copy of the order shall also be communicated to the Chief Secretary of the State for its compliance. 8. Disposed of. (Virender Singh, C.J.) (Shree Chandrashekhar, J.) Satish/LAK

Unmet Need for Contraception

In January 2018, Human Rights Law Network along with petitioner Bihar Voluntary Health Association filed a public interest litigation petition in the Supreme Court of India regarding the lack of access to contraceptive information and services across the country. As of 2010, the unmet need for contraception amongst married women aged 15-49 stands at 21.3%, according to the 3rd District Level Household and Facility Survey. This rate soars to as high as 55.5% in States such as Meghalaya.

Despite this, the Government of India has committed to increased spending and dissemination of contraceptive information and services. At the 2012 London Family Planning Summit, India pledged to spend Rs. 12,000 Crore of federal funding from 2012 to 2020 on family planning. However, upon a perusal of the Ministry of Health and Family Welfare's expenditure, the family planning budget has decreased from Rs 79977.25 Lakhs in 2015-2016, to Rs 77665.45 Lakhs in 2016-17 – nowhere near the spending plan that was committed to. In addition to this, 85% of the budget has been allocated for sterilization out of which 71.1% of the budget has been for the female sterilization procedure. There is therefore a total absence of commitment to a range of contraceptive methods, and a biased focus on female sterilization.

1. Himmat Mahila Samooh vs. Union of India & Ors CWP No. 24703/ 2015

Synopsis

This public interest case was filed in the High Court of Punjab and Haryana at Chandigarh

on behalf of Dr. Jagmati Sangwan through Himmat Mahila Samooh, a leading women's empowerment organization in Haryana.

The petitioners seek justice for their fundamental rights on the availability of the contraceptive methods and accessibility. The Punjab-Haryana High Court made an order in 2014 through which, there were many changes brought in the policies and availability of different contraceptive methods.

Facts

The petition was filed by the Human Rights Law Network with technical support from the Center for Reproductive Rights, demands recognition of women's right to contraceptive information and services in Haryana.

The petition argues that the government of India—through the Ministry of Health and Family Welfare, the state of Haryana, and the Department of Women and Child in Haryana—has failed to provide women with access to the full range of contraceptive methods. It asserts that the failure to ensure access to contraceptive information and services violates women's fundamental rights to life and health, nondiscrimination and equality, and freedom from torture and cruel, inhuman, and degrading treatment, as protected under the Indian Constitution and International human rights law.

Order

The honorable Punjab-Haryana High Court has observed after going through the order dated 20.02.2014 seeking the government's response and inviting further pleadings if this reply was unsatisfactory. The government's reply, submitted in February 2014, claims that existing services are adequate and fails to refute the evidence of barriers to contraceptive information and services presented.

After going through the order dated **20.02.2014** (CWP No. 1262 of 2014) passed by the Government on the direction issued by the Court on a writ petition filed by the petitioner, the Court observed that various steps have been taken by the Government to improve the TFR (Total Fertility Rate). Several policies have been evolved and expanded to educate and motivate people and make available different methods of contraception. Sterilization Camps are being organized. The usage of Intrauterine Contraceptives Devices has improved over the years. Sufficient stocks of contraceptives are supplied from the State Headquarter and resultantly, the TFR (Total Fertility Rate) has been reduced, and there is

definite improvement in the unmet need of contraceptives in the State of Haryana. The Court therefore was of the view that the Government has already taken the requisite steps and thus no further directions need to be issued. Thus, the case is disposed off.

In this said case, a judgment was passed by the High Court of Punjab and Haryana at Chandigarh where the availability of Contraceptives in the public health centers was made compulsory.

2. Bihar Voluntary Health Association V. Union of India & Ors. Writ Petition (C) No. 000456/2018

Synopsis

This petition is being filed as public interest litigation under Article 32 to demonstrate the failure of the Respondents in providing adequate access to contraceptive information and services (hereinafter referred to as CIS) in violation of women's fundamental rights to life, health, dignity, and equality under Articles 15 & 21 of the Constitution of India and various international conventions and covenants. Inadequate access to contraceptive information and services leads to unwanted pregnancy, creating mental and physical anguish, increases the need for unsafe abortion, and contributes substantially to India's shameful maternal mortality rate.

The Petitioner, the Bihar Voluntary Health Association (BHVA), is a secular and voluntary association of Social Development Organizations. It is comprised of charitable hospitals and health centres, formed in 1969. BHVA aims at making community health a reality for people, prioritizing the most marginalized and vulnerable people in society. Their mission is to 'reach to the un-reached through Charitable Hospitals, Dispensaries, Health Centers & Voluntary Organizations/Institutions involved in health promotion and also groups, professionals & individuals engaged & dedicated with some concern in health promotion.' They promote social justice in the provision and distribution of health care.

Facts

High unmet needs

As defined by the Government of India in the District Level Household Survey (DLHS) 3 and DLHS 4, which were conducted across the nation, unmet need refers to married women aged between 15-49 years who want to stop or delay childbearing but are not using

any contraception due to lack of availability of contraceptive information, education and services. A limitation of the available data is that there is no indication of unmet need for unmarried women. DLHS 3 indicated that there was a large group of population (20.5%) with unmet need in family planning at the national level, and the 2010 revision of DLHS 3 has alarmingly seen this rate increase to 21.3% nationwide. Trends from DLHS 3 also illustrate that women between 15 to 19 years have an unmet need of 28.3 per cent for family planning, whilst those between 20-24 years have an unmet need of 28.5 per cent. According to DLHS 4, which was conducted in eleven states and one union territory to date, Meghalaya has the highest rate of unmet need among the states recorded through the survey, at 55.5% in total, and a 39.7% unmet need for spacing.

DLHS 4 shows a sharp increase since DLHS 3 in unmet need in every state where the survey has been completed. The figures are displayed in the table below:

State	Unmet Need 2007-08	Unmet Need 2012- 13	Percentage Increase
Arunachal Pradesh	14.3	32.2	17.9
Chandigarh	8.3	12.1	3.8
Goa	28.8	33.5	4.7
Haryana	16	30.4	14.4
Himachal Pradesh	14.9	20.6	5.7
Karnataka	15.8	16.1	0.3
Kerala	16.8	19	2.2
Meghalaya	32.7	55.5	22.8
Mizoram	16.7	21.4	4.7
Punjab	11.9	15.3	3.4
Sikkim	16.1	20.2	4.1
Tamil Nadu	17.9	27.1	9.2
West Bengal	11.6	12.1	0.5

Maternal and child mortality follow high unmet needs

The United Nation's Population Fund (UNFPA) estimates that 1 in 3 deaths related to pregnancy and childbirth could be avoided if all women had access to contraceptive services, including information, counseling, and services. States with high unmet needs for contraception have poor women's health indicators. The government's failure to ensure accessible, acceptable, quality reproductive health services also impacts negatively

upon infant health. The table below illustrates the links between a high unmet need for contraception and poor health indicators, including a high maternal mortality rate (MMR) and infant mortality rate (IMR).

State	Unmet Need	MMR	IMR
Bihar	37.2%	219	42
Jharkhand	34.7%	219	37
Madhya Pradesh	19.3%	230	54
Meghalaya	55.50%	No data	47
Nagaland	41.6%	No data	18
Odisha	24%	235	51
Uttar Pradesh	33.7%	292	50

Every year at least 56,000 women die from preventable pregnancy related causes in India. Approximately 150 women die every day as a direct result of pregnancy. In fact, maternal mortalities in India account for nearly 17% of all maternal mortalities worldwide, a figure which could be dramatically reduced by comprehensive access to CIS. Contraception allows women to space pregnancies or to prevent unwanted pregnancy. In India, where early marriage often results in adolescent pregnancy and an increased risk of death, contraception can represent the difference between life and death.

Economic and Societal Impact of Barriers to Contraceptive Information and Services

In addition to violating women's rights to life, health, and equality, failure to ensure contraceptive information and services devastates India's economy. In 2009, UNICEF estimated that India loses "USD56 billion every year in potential earnings due to adolescent pregnancy... school dropout rates, and joblessness among women." Providing contraception equally to every citizen has the impact of keeping people, especially women, in school longer, allowing them to seek out better opportunities to become economically secure, and in turn bolstering the nation's economy.

Unsafe Abortion

The Ministry of Health and Family Welfare recently recognized that lack of access to CIS leads to increased rates of unsafe abortion, a major contributor to maternal mortality in India. In fact, the DLHS 4 shows that 80% of women seeking abortion services in India

do not use contraception. Maternal mortality from unsafe abortions accounts for roughly 20,000 instances of all maternal death in India.

Lack of Effective Adolescent Sexual and Reproductive Health services

Under the National Health Missions RMNCH+A initiative, Adolescent Friendly Health Services are to be provided, which includes Adolescent Reproductive and Sexual Health (ARSH) services, which are supposed to provide access to reproductive and sexual health information and services, including contraceptive information and services and safe abortion services. However, this remains to be one of the most neglected areas of health service delivery – services are neither coordinated nor consistent, and there is generally both poor awareness and utilization of the services.

Infant and Maternal Mortality

The IMR is particularly high in those states with a high unmet need for CIS. These states missed out on their Millennium Development Goal (MDG) to reduce IMR by a considerable percentage.

State	IMR	IMR- Urban	IMR- Rural	MDG 2015 Target	2015 IMR
Bihar	43	34	44	25	43
Jharkhand	38	27	39	--	--
Madhya Pradesh	56	37	60	37	53
Meghalaya	49	--	--	18	54
Odisha	53	39	55	41	51
Uttar Pradesh	53	37	60	33	52

Lack of access to contraceptive information and services leaves adolescent girls at a higher risk of maternal mortality and morbidity, such as fistula. The World Health Organization in 2014 noted that adolescent pregnancy is a major contributor to both maternal and child mortality. When young women do not have access to CIS, they cannot delay pregnancy after early marriage. Adolescents are more likely to seek unsafe abortions which lead to maternal death. Adolescent pregnancy leads to higher numbers of pre-term births, still births and neonatal deaths. According to the World Health Organization, there is a 50% greater chance of a still birth and infant mortality when the mother is less than 20 years

old as compared to mothers who are between the ages of 20-29. Infant deaths within the first month of life are 50-100% more frequent when the mother is an adolescent. Finally, the rates of preterm birth, low birth weight and asphyxia are higher among children of adolescents.

India's MDG 5 was to improve maternal health, with target 6 of this goal being to reduce the maternal mortality ratio (MMR) by three quarters between 1990 and 2015. Although pregnancy related deaths are declining in India, present statistics still demonstrate that approximately 120 women in India die each day due to pregnancy associated causes. The states of Assam, Uttar Pradesh, Uttarakhand, Rajasthan, Odisha, Madhya Pradesh, Chhattisgarh, Bihar, and Jharkhand have particularly troubling rates of maternal mortality as compared to the national average, demonstrated in the table below.

Maternal Mortality Rates 2011-2013

State	MMR	Intended Target (2015)
Assam	300	136
Uttar Pradesh	285	213.8
Uttarakhand	285	213.8
Rajasthan	244	181.2
Odisha	222	120.5
Madhya Pradesh	221	150.7
Chhattisgarh	221	150.7
Bihar	208	183.9
Jharkhand	208	183.9
INDIA	167	109

The United Nations seeks to bring the global maternal mortality rate to below 70 deaths per 100,000 live births by 2030, as per Sustainable Development Goal 3. This means India has to reduce their percentage by 90 in the next thirteen years, which seems highly unlikely given the current rate.

Saving 23.9 million unintended pregnancies

Through universal access to CIS, the government of India predicts that over 23.9 million of unintended pregnancies will be averted, as per the Family Planning 2020 Vision Document. Of the total live births in India, 5.6% come from women aged 15-19. This means, that if universal access to CIS is attained, then 1.219 million young women will be able to stay in

school, and will not have to potentially dropout to take care of a child they did not intend to have, as they so often have to. This would serve to narrow the current gender equality gap.

Punitive measures and the two-child norm

Although the two-child norm has been officially abandoned by UOI as counterproductive, the practice continues in many states and families are penalized for the third child. This policy serves to disadvantage poor and vulnerable women, as the total fertility rate among poor and illiterate women is 3.47% higher as compared to middle-class women. Poorer women also have a high infant and maternal mortality rate. Considering this, to impose a two-child norm is to widen the inequality gap among the people, as this disincentive would negatively impact on the already deprived sections of society. Seven states in India already have a two-child limit, where punitive measures are taken. These include exclusion from elections, exclusion from receiving ration cards, kerosene and other BPL subsidies, denial of education in government schools, and the refusal of a conditional cash transfer for poor women delivering a third child. These measures currently take place in Andhra Pradesh, Odisha, Maharashtra, Rajasthan, Bihar, Gujarat, and Uttarakhand. Additionally, Assam is currently considering a bill which would ask government employees and local elected representatives who have a third child to resign. This policy would also disqualify any candidate with more than two children from running a local, municipal, or district office.

Expanding the basket of contraceptives

Currently, the Union as well as the State Government provides five main methods of contraception through the national family planning programme: including the condom, the oral contraceptive pill (OCPs), the IUCD and male and female sterilization. There have been some changes in the technology used for most of these methods over the years. Condoms have become lubricated, pills have lowered their oestrogen content, Copper Ts are now available in two versions, and vasectomy has given way to non-scalpel vasectomy. In addition to these methods, emergency contraceptive pills (ECPs) have also been included. However, the Union and State Governments continue to pursue coercive tactics and push sterilization through camps, rather than provide communities with contraceptives, information and services.

Contraceptives in the national list of essential medicines

The National List of Essential Medicines 2011, released by the Government of India, recognizes the importance of a wide variety of contraceptive measures as essential, and also includes multiple forms of contraception in the list.

Free doorstep delivery

The Respondents have failed to implement schemes that guarantee access to contraceptive information and services. These schemes are a part of the Reproductive, Maternal, Newborn, Child Health and Adolescent (RMNCH+A) Services, which fall under the National Health Mission (NHM). The Respondents' contraceptive schemes have failed as a result of incentivized prioritizing of female sterilization targets over women's rights to choice, bodily integrity, bodily autonomy, and equality. The Respondents' doorstep delivery system has also failed, operating without a rights-based approach, adequate resources, and counseling. The relevant parts of the circular on doorstep contraceptive delivery issued by the Ministry of Health and Family Welfare dated 4 August 2011 is set out herein below:

“The Government of India supplies contraceptives such as condoms, oral contraceptive pills, and emergency contraceptive pills to States as part of the free supply and social marketing schemes. However access to these contraceptives is reported to be low because of several causes including delay in making supplies available to sub district level downwards. As such, use of contraceptives in the country has been largely static. On the other hand, unmet need for spacing methods continues to be substantial.

To improve access to contraceptives by the eligible couples, it has been decided to utilize the services of ASHA to deliver contraceptives at the doorstep of households and incentivise her for the effort. To begin with, the initiative is being implemented on a pilot basis in 233 districts in 17 States.”

The Ninth Common Review Mission (held from 30th October to 6th November 2015) which was carried out in 18 states, highlighted the large unmet need of contraception in several pockets of communities due to poor and/or erratic supplies. In many of the pockets, despite contraceptives being available, a lack of training and on hand mentoring meant these said contraceptives were not being distributed by the ASHAs and the Auxiliary Nurses and Midwives (ANMs). In Meghalaya, a state with a colossal 55.5% unmet need, home delivery of contraceptives by ASHAs was said to be ‘almost non-existent’ and their

knowledge and skills on the topic 'poor'. In Jharkhand, counseling on spacing was stated to be 'non-existent', and the same was said for Maharashtra and West Bengal.

Huge vacancies of ASHA posts unfilled

The 12th Five Year Plan acknowledges that gaps in service delivery are a cause of high unmet need. Accredited Social Health Activists (ASHAs) are key administrators of family planning services. The National Rural Health Mission (NHM) guarantees one ASHA worker per 1,000 people. The number of ASHAs engaged under the National Rural Health Mission as of 2014 was 895,826. Using this figure, there should be 1,248,000 ASHA workers in the country, which means there is currently a shortfall of just over 346,000 ASHAs nationwide.

Additionally, of the 8.85 lakh ASHAs currently operating, only 7.99 lakh have been provided with drug kits, which are supposed to include a variety of contraceptives. The Press Information Bureau states that although ASHAs successfully attend to 70 percent of the population, a further 30 percent remains unattended. Upon a 2017 fact-finding, Human Rights Law Network published a report revealing that ASHAs receive poor training regarding contraceptive information and services leading to misinformation, and incentive-based payments where promotion of spacing methods leads to little to no payment results in female sterilization being disproportionately promoted by ASHAs.

The Respondents have failed to ensure that ASHAs have support from Anganwadi Workers (AWWs), and the Anganwadi Helpers (AWHs). A number of AWW positions remain vacant, and have remained vacant for a period of years. Two status reports of the Integrated Child Development Scheme, from 2013 and 2014 show that thousands of AWW and Anganwadi Helper positions that have remained vacant for at least two years. Nationwide, in 2013 there were 100,212 vacant AWW positions and 90,671 vacant AWH positions. By 2014, the number of vacant positions nationwide as sanctioned by the Central Government had only reduced to 91,263 vacancies. As for the vacant AWH positions, that had only reduced to 83,243. Specific states contribute disproportionately to the large number of vacancies: Jharkhand (3,796), Madhya Pradesh (6,378), and Uttar Pradesh (12,038). Other states have seen increases in the number of vacancies between the two years, Jharkhand (1799), Madhya Pradesh (5,137), Mizoram (101), and Uttar Pradesh (1,288). At the same time, the Respondents have failed to ensure an adequate number of AWCs and Mini AWCs. The number of sanctioned AWCs/Mini AWCs in 2014 is 1,374,935. In March 2014 only 1,342,146, operated – a shortfall of 32,789 AWCs/mini-AWCs nationwide. Furthermore, only 1,318,247 of the operational AWCs/mini-AWCs

report back to the government, which means that the Central government is unaware of the work that 23,899 AWCs/mini-AWCs are doing. Between the shortfall and the centres that are not reporting, there are 56,688 centres that the government fails to account for.

Increasing unmet needs and decreasing budgets

During the 2012 London Summit on Family Planning, the government of India used an international platform to commit to spending Rs. 12,000 crores of federal funding from 2012 to 2020 on family planning, a commitment that is not grounded in reality, as the next paragraph will demonstrate. This proposed funding was said to go towards ensuring that 48 million additional women are covered by CIS, and sustain the 100 million that are currently covered by CIS. This was not going to cover the remaining 21.3% of people currently lacking access to CIS, and does not include providing CIS access to men.

Despite the unmet need increasing to 21.3% from 20.5%, the family planning budget has decreased from Rs 79977.25 lakh in 2015-2016, to Rs 77665.45 lakh in 2016-17. Thus in the face of rising inaccessibility to reproductive health, budgets are being slashed.

Perverse expenditure logic

Across India there has been a push for coercive sterilization methods over other contraceptive methods. This is evident in the budget allocated for family planning by the Ministry of Health and Family Welfare, Government of India. As per the reports published by Population Foundation of India, 'Health Budget Infograph' and "Contraceptive Method Mix" Source: Ministry of Finance, 2014-2015, only 1.5% of the family planning budget has been allocated for spacing methods, whereas a colossal 85% of the budget has been allocated for sterilization out of which 71.1% of the budget has been for the female sterilization procedure and 13.5% of the budget has been allocated for salary and equipment. Thus in addition to the budget being too low, it is also failing to adequately fund a full range of contraceptive methods. When only sterilization is prioritized, adolescent girls, unmarried girls and women, and those seeking to space pregnancies are excluded from accessible family planning. This demonstrates that women from marginalized and poor communities especially have a lack of choices for modern temporary methods, as well as a lack of contraceptive counseling services via doorstep delivery as promised by the Union and the State Government.

Population Control prevails rather than Reproductive Rights

In the landmark judgment in *Dewika Biswas v. Union of India & Ors.* [WP (C) 95/2012], the Supreme Court ordered the government to stop carrying out target-driven sterilization camps, which were discouraged by the National Population Policy 2000. In this petition, it was highlighted that the government were prioritizing population control measures over upholding women's reproductive rights. Despite this, female sterilization receives a vast majority of family planning funding and continues to be the most common form of contraception, even when compared with other countries in the South Asian region. Determining that Article 21 includes the reproductive rights of a person, the Supreme Court held that reproductive rights include the right to 'access a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free, and responsible decisions about their reproductive behavior.'

This is further demonstrated by the incredibly unequal distribution of family planning methods used in India as compared to other countries in the South Asian region. In India, 74.4% of all contraceptive methods used was female sterilization, with only 11.4% condom usage, and 7.5% using oral contraceptive pills (OCPs). Male sterilization accounted for a miniscule 0.6% of usage, demonstrating the onus put on women regarding sterilization procedures. India's extreme emphasis on female sterilization is reflected further when comparing its statistics to other states in the South Asian region. In Bangladesh, 52.4% of contraceptive users were using oral contraceptive pills (OCPs), with only 9.6% using female sterilization as a method. In Bhutan and Indonesia, the most used contraceptive method was the injectable, and both Bhutan and Nepal had a far higher rate of male sterilization, with Nepal reflecting 18% of contraceptive users and Bhutan reflecting 19.3%. This raises questions as to why the India has such a huge majority of contraceptive users resorting to an irreversible, invasive, and sometimes unsafe practice.

Order

22/ 04/ 2019

The office report indicates that respondent Nos. 1, 2, 9 and 33 have not filed counter affidavit in terms of order dated 30.1.2019 of the Hon'ble Court. Perused the record. It is evident that vide order dated 30.1.2019, Hon'ble Court has been pleased to issue notice with a direction that counter affidavit be filed within four weeks from the date of the order. It was also directed that matter be listed after four weeks. Vakalatnama appears to have been

filed on behalf of respondent Nos. 1, 2, 9 and 33 but till date counter affidavit has not been filed. Ld. Counsel for respondent No.9 submit that he has not received the complete set of pleadings. Learned counsel for petitioner is directed to provide the copies of the pleadings to the learned counsel for said respondent within a weeks' time and file proof. Ld. Counsel for respondent No.1 submits that he has already filed the vakalatnama and counter affidavit. Registry is directed to verify the same and report accordingly. Service of notice is complete qua respondent Nos. 3, 5, 7, 8, 10 to 17, 19-26, 28-32 but no one has entered appearance on their behalf. Ld. Counsel for respondent Nos.11 and 13 submits that he has already filed the vakalatnama. Registry to verify the same. Mr. Siddhesh Kotwal, Ld. Counsel appearing on behalf of Ms. Astha Sharma, Ld. Advocate-on-Record seeks and is given two weeks' time to file the vakalatnama and four weeks' time to file the counter affidavit on behalf of respondent No.21 (State of Mizoram). The office report indicates that the vakalatnama filed by the learned counsel for the respondent No.6 is defective. The learned counsel shall within a period of four weeks cure the defects whatever have been found in the said vakalatnama. As per postal tracking report, notice issued to respondent Nos. 4 and 8 could not be served and returned back undelivered. Hence, learned counsel for petitioner shall, within a period of four weeks', file fresh particulars of the said respondents and shall take requisite steps for the service of notice upon them and in respect of respondent No.27 through the Ld. Standing Counsel representing the State. Appearing respondents are free to file the counter affidavit in terms of the order of Hon'ble Court dated 30.1.2019.

List again on 18.9.2019.

3. Sarita Barpanda Vs. Union of India WP No. 5541/ 2019 & CM APPL. 24304/ 2019

Synopsis

On one hand government promotes family planning and awareness about sexually transmitted diseases and how to prevent them, and on the other government is obstructing and banning advertisements of condoms, which generate awareness of family planning. Condoms can prevent the spread of: HIV, Gonorrhoea, Chlamydia, Trichomoniasis, Herpes, Syphilis, and Chancroid. Using a condom can also reduce the risk of cancer from HPV (genital warts) and protects from getting an STD. Considering this, banning advertisement of condoms will lead to increase in such diseases.

Advertisements cannot be said to be obscene just because they feature content related to sex. The term “obscene” is not defined anywhere, as per *Aveek Sarkar v. St of WB*¹ case, the court observed that *“None has so far attempted a definition of obscenity because the meaning can be laid bare without attempting a definition by describing what must be looked for. It may, however, be said at once that treating with sex and nudity in art and literature cannot be regarded as evidence of obscenity without something more. The test of obscenity must square with the freedom of speech and expression guaranteed under our Constitution. This invites the court to reach a decision on a constitutional issue of a most far reaching character and it must beware that it may not lean too far away from the guaranteed freedom.”*

That consistent condom use has been one of the most critical aspects of NACO’s prevention strategy for HIV/AIDS control. Contribution of Condom Promotion Programme in National Condom Promotion Programme: (i) Total Condom Distribution has grown from 1.8 billion pieces in 2007-08 to 2.7 billion pieces in 2012-13 (Source: NIELSEN and Ministry of Health & Family Welfare). (ii) Accessibility of condoms at any location of walking distance has been reduced from 30 minutes to 19 minutes (15 minutes in Urban and 21 minutes in Rural) (Source: Condom Promotion Impact Survey 2010). (iii) Deluxe Nirodh continues to maintain its market share at 17% which is highest among all individual brand variants in overall condom market (Source: NIELSEN). (iv) Rural paid condom market has grown by 70% during 2007-08 and 2012-13. During the same period rural social marketing condom market has grown by 42% (Source: NIELSEN). Thus, government must spread more awareness for the usage of condoms and banning such ads leads to deprive people from being informed about it.

We cannot say that these ads are obscene as they are useful for increasing the use of condoms, and banning them from television could lead to an increase in various STDs. There are adolescents who require information and knowledge about the contraceptives available in the market, and banning such advertisements will hamper them to be informed which leads to increase in low sex education among them usage of condoms also.

The Hon’ble Court in the case of *Ranjit D. Udeshi v. State of Maharashtra*², held that *“A balance between freedom of speech and expression and public decency and morality has to be maintained and the former must be restricted only if the latter is substantially transgressed.”* It further stated that, *“Books on medical science with intimate illustrations and photographs,*

1. 2014) 4 SCC 257.

2. 1965 AIR SC 881

though in a sense immodest, are not considered to be obscene but the same illustrations and photographs collected in book form without the medical text would certainly be considered to be obscene." Thus these condoms advertisements are also useful spreading message to use condoms as contraceptives which is social need of an hour; hence, these advertisements should not be banned.

The advisory banning the condoms advertisements violates fundamental rights under articles 14, 19(1) (a) and 21 of the general citizens. Not being informed about the condoms available in the market leads to unwanted pregnancies which will directly affect their dignified life and violate article 21 of the people who are not able to receive information because of banning such advertisements. The Right to Life includes reproductive rights which include the right to 'access a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free, and responsible decisions about their reproductive behaviour. The protection of 19(1) (a) is available to recipient of the advertisements and thus banning advertisements violates article 19(1)(a) of the recipients. As per *TATA Press Ltd v. Mahanagar Telephone Nigam Ltd.*³, the honourable Supreme Court observed that "*.....Examined from another angle, the public at large has a right to receive the "commercial speech". Article 19(1)(a) not only guarantees freedom of speech and expression, **it also protects the rights of an individual to listen, read and receive the said speech.** So far as the economic needs of a citizen are concerned, their fulfilment has to be guided by the 'information disseminated through the advertisements. The protection of Article 19(1) (a) is available to the speaker as well as to the recipient of the speech. The recipient of "commercial speech" may be having much deeper interest in the advertisement than the businessman who is behind the publication. An advertisement giving information regarding a lifesaving drug may be of much more importance to general public than to the advertiser who may be having purely a trade consideration. We, therefore, hold that "commercial speech" is a part of the freedom of speech and expression guaranteed under Article 19(1) (a) of the Constitution.*" So the advisory which banned condoms advertisements violates articles 19 (1) (a) and 21, and in turn also violates article 14 by not providing equality before law.

Banning advertisements also violates the fundamental rights of advertisement companies as they are barred to freedom of speech and expression i.e. article 19(1) (a). As per *TATA Press Ltd v. Mahanagar Telephone Nigam Ltd.*⁴, Supreme Court held that commercial speech is a part of freedom of speech and expression. Hence advisory violates the freedom of speech and expression of advertisement co. by this their right to livelihood is also affected;

3. 1995 AIR SC 2438

4. 1995 AIR 2438

hence, article 21 right to life is also violated. By this, they are not getting equality before law, thus their article 14 is also violated. Hence by this advisory, article 14, 19(1) (a) and 21 of people and advertisement companies are affected.

Facts

The Ministry of Information and Broadcasting issued Advisory No. 40011/01/2014-BC-1 banning condom commercials from being televised outside the time frame of 10 pm – 6 am, referring to violation of Rule 7(7), 7(8) of the Cable Television Networks Rules, 1994. Invoking Rule 7(7) by stating such advertisements to be ‘endangering the safety of children’ and 7(8) since advertisements was indecent, vulgar, suggestive or had repulsive themes. The Advisory stated that such advertisements must only be shown within the time specified in order to ensure strict adherence to the above mentioned rules.

This is matter of public health care as condoms, aside from being contraceptives for preventing unwanted pregnancies, also prevent the spread of sexually transmitted infections and diseases such as: HIV/AIDS, Gonorrhoea, Chlamydia, Trichomoniasis, Herpes, Syphilis, and Chancroid. Using a condom can also reduce the risk of cancer from HPV, more commonly known as genital warts. Of all forms of contraception, condoms are the only method to prevent sexually transmitted diseases as well as prevent unwanted pregnancies.

The National List of Essential Medicines 2015, released by the Government of India, recognizes the importance of a wide variety of contraceptive measures as essential, and includes condoms as a ‘barrier method’ of contraception in this list at Section 21.2.2.1.

The aforementioned Advisory will serve to limit the efforts of schemes which are a part of the Reproductive, Maternal, Newborn, Child Health and Adolescent (RMNCH+A) Services, which fall under the National Health Mission (NHM). Such limitations would result in a failure in prioritizing targets by aiming for “population control” over women’s rights to bodily integrity, bodily autonomy, and equality.

Increasing awareness of condom usage is crucial not just for the general public but for health workers as well. ASHA (Accredited Social Health Activist) workers, who are mandated to counsel uninformed people about contraception and general family planning, lack the proper training and information required for efficient prevention of diseases and unwanted pregnancies. ASHA workers receive incentive-based payments which are heavily geared towards encouraging female sterilization procedure over the supply of spacing methods such as condoms. ASHA workers receive Rs. 200-300 for facilitating vasectomy as opposed

to Re. 1/- for supplying condoms and are also encouraged to distribute condom supplies pass their expiry date. This puts the pressure of contraception on female and feeds into the unequal gender hierarchy present in Indian society. One of their main tasks regarding counseling married couples who are non-users leaves a huge gap between the counselling received by the unmarried couples, which points to the need of awareness about condoms.

The quality of training of ASHA workers further proves the need for more efficient promotion of condom usage to increase awareness and prevent the spread of misinformation. In Wazirabad, frequent bribery and coercion by ASHA workers of street-dwelling men, whom the ASHAs believed to have had contracted HIV, to go for vasectomies in order to receive the cash incentive, was observed. This indicated gross misunderstanding of role of condoms in protecting individuals – as vasectomies do not prevent the spread of HIV, only condoms do this.

This Advisory would further fuel the stigma attached to the usage of condoms, which through research has been identified as: alleged decrease in male sexual pleasure, and usage an indication of infidelity or promiscuity. Such stigmas usually result in the onus of contraception being on females, prioritizing female sterilization and domestic violence. NFHS 4 found that 3.3% of women across India aged 15-49 years experienced violence during pregnancy. Female sterilization is the most common method of contraception used in India accounting 75.5% of India's mCPR according to Family Planning 2020.

The Advisory issued by the government should not deviate from its family planning objectives. The Family Planning Programme, which includes both limiting and spacing methods of contraception, currently has an annual budget of Rs 77665.45 lakhs as of 2016-2017. This is a decrease from the annual budget of Rs 79977.25 lakhs from 2015-2016, which is worrying considering the increase of unmet need identified by the DLHS surveys. The Press Information Bureau state that the Government is taking steps under the FP2020 UN Programme to increase contraceptive choices and launch campaigns to generate awareness around family planning.

That usage of condoms would pose a solution to the 'unmet need' mentioned in the District Level Health Survey (DLHS-4). The Government of India, in the District Level Health Survey (DLHS-4), defines "unmet need" as "the percentage of currently married women who either want to space their next birth or stop childbearing entirely but are not using contraception." In 2007-2008, the overall unmet need in India was 20.5% which has increased to 21.3% in 2010. This means that over one fifth of couples and women who wish to delay or prevent pregnancy in India have no means of doing so. Condoms are the

only form of contraception that would address unmet need and address sexually transmitted diseases and infections, as well as being completely safe to use for both men and women.

The right to health is an integral part to the right to life under Article 21 of the Constitution of India. In *Paschim Banga Khet Mazdoor Samiti vs. State of West Bengal and Another* [(1996) 4 SCC 37]

The need for an increase in awareness about condoms is demonstrated by The Ninth Common Review Mission (held from 30th October to 6th November 2015) which was carried out in 18 states highlighted the large unmet need of contraception in several pockets of communities due to poor and/or erratic supplies. In many of the pockets (states like Meghalaya, Jharkhand, Maharashtra, West Bengal), despite contraceptives being available, a lack of training and on hand mentoring meant these said contraceptives were not being distributed by the ASHAs and the Auxiliary Nurses and Midwives (ANMs).

There has been an increase in unmet need in every state since DLHS-3 was conducted. The figures are displayed below.

State	Unmet Need 2007-08	Unmet Need 2012-13	Percentage Increase
Arunachal Pradesh	14.3	32.2	17.9
Chandigarh	8.3	12.1	3.8
Goa	28.8	33.5	4.7
Haryana	16	30.4	14.4
Himachal Pradesh	14.9	20.6	5.7
Karnataka	15.8	16.1	0.3
Kerala	16.8	19	2.2
Meghalaya	32.7	55.5	22.8
Mizoram	16.7	21.4	4.7
Punjab	11.9	15.3	3.4
Sikkim	16.1	20.2	4.1
Tamil Nadu	17.9	27.1	9.2
West Bengal	11.6	12.1	0.5

If there is unhindered access to contraceptive information and services, infant mortality will decrease. Spacing pregnancies saves lives. Where a woman becomes pregnant within 15 months of her last pregnancy, prenatal mortality is 71 per 1,000 pregnancies. Comparatively, if a woman has access to spacing methods and an interval between pregnancies of at least

27 months, the prenatal mortality rate decreases to 30-31 per 1,000. The Infant Mortality Rate is high in states with high unmet needs for contraceptive information and services. The need for awareness about condoms is thus dire. As seen in the table below:

State	IMR	IMR- Urban	IMR- Rural	MDG 2015 Target
Bihar	43	34	44	25
Jharkhand	38	27	39	--
Madhya Pradesh	56	37	60	37
Meghalaya	49	--	--	18
Odisha	53	39	55	41
Uttar Pradesh	53	37	60	33

It is evident from the National Family Health Survey-4 (NFHS-4) of 2015-2016 that the onus of family planning and related healthcare continues to fall on the woman in India. This inequality could be avoided with increase in awareness about contraceptives like condoms. The data from NFHS-4 with regards to sterilization for family planning in India is represented below:

Family Planning Method	Urban	Rural	Total
Female Sterilization (%)	35.7%	36.1%	36%
Male Sterilization (%)	0.3%	0.3%	0.3%

That there should be more efforts made in the promotions of usage of condoms to combat the inefficiencies of National Population Policy, 2000, Janani Surakshya Yojana (JSY), and Adolescent Sexual Reproductive Health (ASRH). These policies of the government obligate the states to provide free condoms among other utilities.

These sterilisation methods however fail to prevent the spread of sexually transmitted diseases and infections. Condoms should thus be promoted to ensure both prevention of unwanted pregnancies (which may lead to abortions conducted in an unauthorized or unsafe manner) and protection against sexually transmitted diseases and infections.

Children should not remain ignorant of the usages of contraceptives like condoms and the benefits of safe-sex. Since in India younger girls are highly prone to deaths from pregnancies they should have access to sex-education at an early age. India's MDG 5 was to improve maternal health, with target 6 of this goal being to reduce the maternal mortality

ratio (MMR) by three quarters between 1990 and 2015. The UNFPA states that India ranks among the top ten countries with the greatest numbers of women aged 20-24 who gave birth by the age of 18. Although pregnancy related deaths are declining in India, present statistics still demonstrate that approximately 120 women in India die each day due to pregnancy associated causes.

The Maternal Mortality Rate can be reduced if there is universal access to information about contraceptives like condoms. It is similarly estimated according to India's Vision FP 2020 issued by the Ministry of Health and Family Welfare, dated November 2014 that India can reduce up to 90% of maternal mortalities associated through this method. The states of Assam, Uttar Pradesh, Uttarakhand, Rajasthan, Odisha, Madhya Pradesh, Chhattisgarh, Bihar, and Jharkhand have particularly troubling rates of maternal mortality as compared to the national average, demonstrated in the table below.

Maternal Mortality Rates 2011-2013

State	MMR
Assam	300
Uttar Pradesh	285
Uttarakhand	285
Rajasthan	244
Odisha	222
Madhya Pradesh	221
Chhattisgarh	221
Bihar	208
Jharkhand	208
INDIA	167

1) Tables showing NFHS-4 data about the use of condoms in India and in the territory of NCT Delhi are given below.

Territory	Condom usage in Urban Areas (%)	Condom usage in Rural Areas (%)	Total condom usage (%)	Total usage in 2005-06 from NFHS-3 data
India	9.0	3.6	5.9	5.2
Delhi	19.0	13.9	19.0	22.9

The government has made significant efforts in promoting awareness of contraception like condoms. The Ministry of Health & Family Welfare has multiple schemes guaranteeing provision of contraceptive information and services, as well as a core mission to provide universal coverage of health care, including family planning services. The Ministry states that family planning services are not a privilege, but a “basic human right.” Family planning schemes are one of the major components of the Reproductive Maternal, Newborn, Child and Adolescent Health Programme, which is sub-component of the much larger, National Health Mission.

Increase in use of condoms will lead to a more safer and healthy India. A 2013 study has pointed out an increasing usage of modern contraceptives by 4-8 percentage points fuelled by the additional contraceptive methods (7+ from previous 4) being made available over 27 years. NFHS-4 reflects on the Modern Contraceptive Prevalence Rate (hereon referred to as mCPR) of 47.8 and proves the consequence of inaction in terms of increase in awareness—since India’s mCPR should have been 59.8% in 2016-17, if eight methods of contraception had been made available.

Country	Condom usage (%)	Most preferred contraceptive (%)	Comparison of Female sterilisation with Male sterilisation	mCPR
Bangladesh	11.9	Pills (50%)	Female sterilisation > Male sterilisation by 6 percentage points approx..	55.6
Bhutan	8.4	Injectable contraceptive(44.1%)	Female sterilisation< male sterilisation by 9 percentage point approx.	63.9
Indonesia	2.6	Injectable contraceptive (45.1%)	Female sterilisation < male sterilisation by 1 percentage point approx.	59.1

Nepal	7.8	Female sterilisation	Female sterilisation > male sterilisation by percentage 37 percentage point approx.	49
Sri Lanka	10.4	Female sterilisation	Female sterilisation > male sterilisation by 30 percentage points approx.	56.1
India	11.7	Female sterilisation	Female sterilisation > male sterilisation by 75 percentage points approx.	47.8

India has the lowest mCPR among its South-east Asia countries neighbours and part of the reason is accounted for by the high rate of female sterilisation and low rates of other safer methods available and used. While data is available from the National Family Health Survey (NFHS) 4 for five methods, in March 2016, India added three more methods to its family planning programme. Therefore currently there are a total of eight methods available. India albeit is the only country in this group with only 5 no. of methods used unlike the 7 or above methods used in other countries. This low mCPR can be changed with increase in awareness about the benefits of alternative methods of contraception like condoms, which offer a safer method of preventing disease distribution as well.

A study done in Pakistan indicates that condom advertising was effective in increasing condom use in urban Pakistan and can be similarly applied in India with efficiency. Research was done on the Touch condoms appearing on private TV channels and on radio stations in urban Pakistan and its impact, from a national survey of men married to women aged 15–49 on the ‘conditional change regression’ analysis to ‘determine whether awareness of the Touch ad at follow-up was associated with improved attitudes toward condoms and condom use.’ The respondents who had limited awareness of the campaign overcame the socioeconomic and demographic barriers and experienced the following from their first time exposure: ‘increase in the following: perceived availability of condoms; discussion of family planning; approval of family planning; procurement of condoms; and ever use, current use, and consistent use of condoms with wife’.

That this particular issue cannot just be tackled with awareness in rural areas but urban

areas also requires active promotion of condom usage to prevent higher HIV prevalence. Myanmar, for instance, currently has the second highest number of people living with HIV in the Southeast Asia region and is a UNAIDS country of concern. New infections are mostly found in urban areas or areas where drug use is endemic. For example in the country's largest city, Yangon (formerly known as Rangoon), there appears to be a higher rate of partner change, a higher rate of buying sex and injecting drugs, lower knowledge on HIV transmission and prevention, lower contact by outreach workers and a lower rate of condom use, all resulting in higher HIV prevalence.

The Prime Minister Anand Panyarachun considered the issue an urgent priority and supported the national launch of the programme. Within three years, condom use among sex workers increased from less than 25% to more than 90%, according to the Department of Disease Control. In the 10 years between 1991 and 2001, new HIV infections dropped from 143,000 per year to less than 14,000. The programme was so successful that similar campaigns were started in Cambodia, China, the Lao People's Democratic Republic, Myanmar, the Philippines and Vietnam.

In Thailand, HIV rates of 0 to less than 1% among injecting drug-users (IDU) in Bangkok were found in various ad hoc surveys from 1985 to 1987. However, HIV rates increased sharply to 40% by September 1988. The June 1999 sentinel surveillance results show the average prevalence rates in Thailand of 51.1% among IDUs, 16.6% in female sex workers, and 1.7% among pregnant women. Northern provinces are more severely affected. In Manipur, North-East India, the epidemic which was mainly confined to injecting drug users, is now spreading into the general population as well. In Mumbai, the HIV seropositivity rates among sex workers and STD patients are now 51% and 35% respectively. The rate among sex workers in Tamil Nadu in 1996 was 30%. There is evidence of an increase in HIV among women attending antenatal clinics; the seroprevalance rates in 1999 in Bombay, Tamil Nadu, Manipur, Karnataka and Andhra Pradesh during 1999 were in excess of 1%.

With a large population size, China's campaign proves that results are possible with active involvement in increasing awareness about the issue among different sections of society. China has less than 0.1% of adult HIV prevalence in 2014. HIV prevention programmes have consistently developed across the country in the last decade, as observed from China Ministry of Health (2014) 'China Country Progress Report 2014. Reducing sexual transmission of HIV has largely been tailored to the key affected populations at greater risk of HIV. In 2014, large-scale publicity campaigns and education activities focused on migrant workers, teenagers and women.



China (2015)

501,000 people living with HIV (2014)

<0.1% adult HIV prevalence (2014)

115,000 new HIV infections (2015)

21,000 AIDS-related deaths (2014)

295,398 adults on antiretroviral treatment (2014)

Source: China Health & Family Planning Commission & China National Centre for STD/AIDS Prevention and Control

India has the potential to adopt several schemes to combat the lack of awareness about HIV and uses of contraceptives like condoms. Campaigns which have had success in China like the Red Ribbon Health Campaign of 2013 that targeted university students to educate students, worker groups, non-local migrant workers and businesses about HIV prevention information. China's recent national prevention efforts have also focused on serodiscordant couples, providing treatment for the HIV positive spouse, as well as condom promotion and HIV testing. Between 2009 and 2014, the level of transmission between serodiscordant couples dropped by 76%.

The rural and remote sections of India should not be blinded from the benefits of using contraceptives like condoms. This dire need for information is evident in northern Bihar, where migrant men were found to be eight times more likely to have HIV than non-migrant men. It was also found that male and female migrants engaged in high levels of extra-marital sex and low condom use. A 2012 study also found that 47% of truckers reported paying for sex, of whom only 40% had used a condom. Of those surveyed, 47% were unaware that HIV could be transmitted through heterosexual sex.

India now has the third largest HIV epidemic in the world, which begs for more policies addressing the lack of belief in contraceptives like condoms which prevent the spread of HIV/AIDS. Government efforts for behaviour change and generation of demand for condoms and other prevention commodities should be the key focuses and such efforts should be encouraged. Increasing awareness among the general population and key affected groups about HIV prevention is a central focus of India's current National Control Programme (NACP IV), which has been implemented between 2012 and 2017.

Data collected by UNAIDS in Thailand, shows that there is direct relation with usage of condom and decline of STIs. There was such a decline in STIs due to educating publicizing “No condom No sex” policy.

Later Cambodia also initiated that policy to decrease STIs and their campaign was also successful. After these success stories, the program was expanded to China, Laos PDR, Mongolia, Myanmar, the Philippines and Vietnam. The study done by Zhang and partners showed that HIV prevalence among female sex workers in China had stabilized at 0.36% there is another study done by Andrew and his colleagues which showed that 97% of the time, female sex workers uses condoms in Laos. Thus, these are the evidence that condoms play very significantly role in decline of STI and HIV.

According to the data of Department of Disease Control in Thailand, usage of condoms among sex workers was increased from less than 25% to more than 90% which results in drop of new HIV infections from 143,000 per year to 14,000. To fight the issue of increasing rates of STDs, an advertising campaign was started in 2007 with slogan “Yued ok pok thung” which means ‘proud to carry condoms’.

It can be deduced from surveys that most men became aware of using condoms from mass media campaigns (televisions, radio, and newspaper) and the campaign got the cooperation from various agencies. Such messages were the part of National AIDS education and condom promotion campaigns. From the survey among sex workers, it was clear that most of their awareness and information about the Condom Promotion Campaign came from television or health care workers. In 100% condom programme, mass media provided a lot of information about AIDS and usage of condoms.

The state program implementation plan (SPIP) approved for family planning to each state, which they have to spend for welfare in next financial year. The expenditure is much less than what was budgeted for every state, with the exception of West Bengal and Andhra Pradesh. There are 12 states and UTs: Bihar, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Punjab, Rajasthan, Tamil Nadu, Uttarakhand, and Puducherry, which spent between 50 to 90 percent of their budget. 10 states: Assam, Chhattisgarh, Haryana, Himachal Pradesh, Kerala, Mizoram, Nagaland, Tripura, Sikkim and Uttar Pradesh, which spent 50 to 30 percent only. Shockingly, there are 13 states and UTs: Arunachal Pradesh, Chandigarh, Delhi, Goa, Jammu and Kashmir, Manipur, Meghalaya, Telangana, Lakshadweep, Dadra and Nagar Haveli, Daman and Diu, Chandigarh and Andaman and Nicobar, which just spent less than 30% of the budget allocated to them.

Aside from educating young citizens and key groups affected by HIV, there is a need for access to, availability of and affordability of condoms in rural and remote areas. The Condom Social Marketing Programme (CSMP) aims to promote safer sex. A key focus of the programme is making condoms readily available in rural and remote areas and in high-risk places such as truck stops. In 2015, the CSMP distributed more than 2.83 million condoms.

That there is a lack of open discussion observed in the conservative society of India on topics related to sex and use of condoms. This taboo attached to such issues may play a role in the low awareness and decreasing use of condoms in India.

That the Advisory issued by the Government only serves to further stigmatize the use of condoms by making them appear indecent or vulgar. This would hamper the efforts made by NGOs and other organisations in spreading awareness about the benefits of using condoms.

That hence, fundamental rights of the general public under Art 21 of the Constitution have been violated as Art 21 includes the right to health. Further, rights under Art 19(1) (a) have also been curtailed as the Advisory unfairly curtails free speech by restricting commercial advertisements.

Order

21. 5. 2019

The Hon'ble Division Bench- I (Coram: Hon'ble the Chief Justice and HMJ Anup Jairam Bhambhani) could not assemble today.

List on 08. 07. 2019.

Preventable Maternal Deaths

Maternal mortality is not just a public health issue; it is also a serious violation of some of the most fundamental of human rights. Maternal Mortality Ratio (MMR) is very high in India. Even in 2010 India has MMR of 200/100,000 live birth. ¹As compared to 21/100,000 live birth in USA, 15/100,000 live birth in New Zealand, 12/100,000 live birth in UK, 8/100,000 live birth in Switzerland and in France. Even the neighbor country like Sri Lanka has MMR of 35/100,000 live birth; Nepal has 170/100,000 live birth. Maternal mortality violates the right to life, as well as the right to liberty and the right to be free from cruel, inhuman and degrading treatment. India has committed to uphold these rights through its various international treaty obligations as well as the Indian constitution.



Children are waiting for their mother's arrival in Mentri Village, Odisha

1. Academike; Articles on Legal Issues; *Maternal Mortality in India*; 17th September 2018 <<https://www.lawctopus.com/academike/maternal-mortality-india/>>

According to World Health Organization, most of the maternal deaths are preventable. The concept of a preventable maternal death, however, is nuanced: a maternal death is more easily prevented in settings with access to health care providers, infrastructure and supplies compared to settings with limited resources. The two main causes for maternal mortality are postpartum hemorrhage and pre-eclampsia/ eclampsia, which are preventable with timely, high quality emergency obstetric care.²

The right to life is guaranteed in the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights. The Human Rights Committee has expressed that this right should not be interpreted narrowly and that protection of this right requires positive measures on the part of the state.³ In its General Recommendation No. 24 on Article 12 of the Convention on the Elimination of Discrimination against Women (CEDAW), the Committee makes states' obligation to prevent maternal mortality explicit. Besides being responsible for reporting on maternal mortality, state parties ensure "women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources."⁴

1. Bharat Sahoo vs. Union of India W.P. (C) No. 17958 of 2016, In the High Court of Orissa, Cuttack

Synopsis

Bharat Sahoo, the petitioner challenged the inaction of the opposite Parties in non-implementation of the welfare schemes by the Department of Health and Family Welfare and Women and Child Development Department. Whereby, the wife of petitioner a pregnant lady died due to negligence and poor treatment by the Community Health Centre and District Head Quarter Hospital, Nuapara while she was undergoing a treatment in the aforesaid Hospital.

Facts

The wife of the petitioner, Late Renubala Sahoo was pregnant for the fourth time. As per guidelines, her name has been registered under Integrated Child Development scheme,

2. Maternal Health Task Force; *Ending "Preventable" Maternal Deaths with Limited Resource: Learning from Successful Country Programs*; < <https://www.mhtf.org/2017/06/05/ending-preventable-maternal-deaths-with-limited-resources-learning-from-successful-country-programs/>>

3. Human Rights Committee, *General Comment 6: The Right to Life (Art. 6)* (16th Sess., 1982)

4. Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Women and Health (*Art. 12*). Doc. No. A/54/38 Rev. 1 (1999)

Mother and Child Tracking System (MCTS) card has been issued in her favour on 27.5.2015 bearing MCTS card No. 212540301311500060 which revealed that her expected date of delivery was on 27.12.2015.

On 22.11.2015 Renubala felt labor pain, therefore immediately her family members tried to contact the ambulance service provided by the Central and State Govt., by 102 & 108 but ambulance did not reach them. When they did not find any alternative, Ranubala's husband Bharat Sahoo called the ANM, who assisted for delivery and ultimately Renubala delivered a girl child at her home. After around two hours Renubala all of a sudden felt chest pain when she was brought to the nearby Hospital for immediate treatment. Unfortunately, due to no doctor present at the hospital she was treated by a staff nurse and soon within an hour Renubala passed away. According to Bharat Sahoo, Renubala was regularly checked up by ANM during her period of pregnancy which was not even a high-risk one.

As per the norms of the National Health Mission a pregnant woman has to be provided antenatal services which include two shots of tetanus injection, four checkups by the ANM, and nutritional support through the ICDS initiative at the village level.

Despite all the provisions under several schemes under National Health Mission, she failed to receive the free ambulance services that is suppose to facilitate the patient's movement from her home to the health services and then back to her home. She was not accorded with the dignity that she deserved and her dead body was sent home in an auto rickshaw wrapped up in a thin sheet.

Prayer

Under the facts and circumstances it is therefore humbly prayed that this Hon'ble Court may graciously be pleased to admit the writ application, issue notice to the Opp. Parties to show cause as to why the reliefs prayed for shall not be granted in favour of the petitioner and if the Opposite parties failed to show cause or showed insufficient causes, the Hon'ble court may further be pleased to issue direction to the Opposite Parties, to pass an order to reimburse petitioner for the expenditures incurred and provide a compensation of Rs. 10 lakhs for mental and physical trauma and for the upbringing Renubala Sahoo,s loss and further be pleased to pass an order for Renubala Sahoo family to receive her financial entitlement under the National Maternity Benefit Scheme(NMBS) and to pass an order to pay Renubala Sahoo's family Rs. 20,0000 under NFBS. And may further pleased to pass such other order/orders, direction/directions may deem fit and proper in the interest of justice.

Order

22.11.2016

The aforesaid case was listed before the Hon'ble High court on 22.11.2016 for admission. In course of hearing the Hon'ble High Court disposed of the Writ Petition in the following observation,

“Considering the contentions of learned counsels for both the parties and pleadings, limited grievances being there for ex-gratia compensation, the writ petition is disposed of with a direction to the petitioner to make a fresh representation enclosing all the documents and certified copy of this order to the opposite party No.5 Collector-cum-Chairman, Zilla Swasthya Samiti Keonjhar within a period of three weeks from today and the opposite party no. 5 would do well to consider and dispose of the representation after given proper opportunity to the petitioner after being heard within a period of two months from the date of receipt of the representation and communicate the decision to the petitioner. It is needless to say that the opposite party No. 5 will pass a speaking order while disposing of the representation of the petitioner.”

Writ Petition is disposed of accordingly.

2. Moba Changkai versus State of Nagaland & Ors, Writ Petition No. 179 (K) of 2016 Guwahati High Court, Kohima Bench

Synopsis

Mon District, the eastern part of Nagaland is one of the most backward districts in the state. Monyakshu, the biggest village under Mon district and one of the most interior villages in Nagaland, of over 6500 population, is situated in the Indo-Myanmar border. About half of the village population is children and an average family comprising of eight to nine family members. Despite a huge population, the village does not have a functioning health centre to cater to the needs of the people and the only Sub-Centre has perpetually remained dysfunctional. The villagers in this area have been neglected by the state authorities wherein there is in absentia of any governmental facilities and services and the lack of accountability on the state authorities has only perpetuated this deliberate negligence leading to human rights violations of securing health care, educational institutes and facilities and poor sanitation.

The cause of maternal deaths and health related problems, in the State of Nagaland, have never been addressed in the court of law. Cases of such nature is one of the first where there has never been intervention, wherein, the organization has taken up the case in filing a petition addressing on the lack of apathy of the state governments and holding them accountable in failing to secure the right to health of the citizens in the village of Monyakshu.

Facts

This writ petition was filed in the Kohima Bench of the Guwahati High Court on account of the maternal death of Lt. Bemang who could not survive her seventh pregnancy, an obstructed labour case due to the non functional sub-centre. The event of the death was attributed to the poor implementation of the government maternal health scheme in the Sub-Centre of Monyakshu under Mon District, catering to a population of about 6500.

The Sub-Centre is defunct, closed throughout the year depriving the communities of Right to Life of good health. The health centre is bereft of any medical facility and services, lack of medical equipments aided by untimely and expired supply of drugs in the centre. The only time it remains open is during immunization drive. This petition was filed after a fact finding was conducted on the maternal death and the health centre. The petitioner prays for compensation against the state authorities who failed in securing the fundamental right to life of good health, equality and dignity enshrined under Article 21, 14 and 15 of the Constitution of India. The petitioner also further seeks for the proper implementation of the maternal health schemes, the Indian Public Health Standard guidelines, conducting of child death review, maternal death review, timely supply of drugs and others.

Development of the case

The fact finding team went to the village of Monyakshu for looking into the aspect of availability of health services. On interaction with the village chairman, a maternal death case was reported to the team, prior to the visit of the team. To understand the issues perpetuating the death, the team went and interacted with the father of the petitioner wherein it was informed that Lt. Bemang died on her way to Mon District Hospital because the Sub-Center, located just half a kilometer away from the residence of the petitioner was defunct and closed.

The mother died on her way, due to obstructed labour case. A close study of the report finds that the dilapidating structure and the dysfunctional center was one of the reasons for

the cause of death. With no visit from the doctor, lack of services and facilities, disabling the mother in availing any kind of treatment or test prior to her pregnancy, lack of referral services and no timely intervention in time of medical need were some of the reasons which resulted in the untimely death. On further interaction it was also observed that the village of Monyakshu, there was a high prevalent case of child deaths. The deceased's two children, below the age of 5 years, had also succumbed to it.

A petition has been filed in the Kohima Bench of the Guwahati High Court. The petition seeks for direction and implementation of, the Indian Public Health Standards in the sub-centre, conducting of the maternal death review, carrying out child death review in the village of Monyakshu, availability of referral services, granting of the maternal benefit scheme, National health Mission, scheme under JSY and JSSK ensuring maternal care to women, granting a lump sum amount of Rs 20000 under the National Family Benefit Scheme on account of dead of primary bread winner of a family to be furnished by the Social welfare Department in the State of Nagaland.

Order

27. 09. 2017

The case was listed for motion on 27.09.2017 and notice was issued to the respondent parties. However, even after the lapse of 7 months the respondents have not filed the counter affidavit in the court. On the last date of hearing, the court has granted further time, as last chance to the respondent authorities to file the response.

3. Alin Kumar Sasmal vs. State of Orissa & Others W.P. (C) No. 5428 of 2016, In the High Court of Orissa, Cuttack

Synopsis

The petitioner in the present writ application seeks to highlight the failure of state agencies in the proper implementation of necessary provisions of the National Food Security Act, 2013 and deficiencies in the implementation of schemes, meant to reduce infant mortality and maternal mortality funded by the Government of India implemented through Government of Odisha. The issues concern is the systemic failure, which has resulted in denial of benefits to Gouri Sasmal, during her pregnancy, under the Janani Suraksha Yojana (JSY), the Mamata Schemes and the ICDS initiative no support has been provided to her, which she is legally

entitled to get the benefits. Although the interrelatedness of these schemes was recognized by the Supreme Court way back in an order dated 28th November 2001 in Writ Petition No. 196 of 2001 (People's Union for Civil Liberties v. Union of India, (hereafter the PUCL Case) and thereafter periodically orders by way of mandamus have been issued to the Union of India and the individual states, much remains to be done on the ground, as the case of Gouri Sasmal reveals. Gouri Sasmal's death fits into the internationally accepted definition of maternal death in terms of the period of death and the cause of death. Gouri Sasmal died in the labour room itself, as no doctor has attended her nor she was treated properly in the District Headquarter Hospital, Balasore.

Facts

Facts leading to the present case are that the victim was a pregnant lady registered with the ICDS Centre of Kainagari-1 under Integrated Mother and Child Development Scheme on 11.05.2015, her last monthly period was 19.2.2015 and her expected date of delivery was 26.11.2015.

That the petitioner belongs to BPL category and it was her first pregnancy. She availing the antenatal care at the Sub-Centre regularly i.e., 19.05.2015, 16.06.2015, 19.10.2015 and 17.11.2015 at Sahada. On 01.06.2015 she has been to CHC, Basta for her check-up, where the doctor on duty advised her for some test and advised to take medicine accordingly, she was under medication.

That while going through all of a sudden the wife of the petitioner developed labour pain on 29.11.2015 at about 2.00 pm, immediately the petitioner called the ASHA to accompany them to the hospital and to call the 102 Ambulance i.e., Janani Express.

They waited for two Hours for the 102 Ambulance, when the Ambulance reached at the village, they went to CHC, Basta and reached there at 2.45 PM and the duty doctor admitted her as outdoor patient initially vide OPD No. 6638 and when the condition of Gouri became serious she had been admitted as an indoor patient and the doctor treated her and delivered a male child, the mother of the newborn child became serious and there was profuse bleeding and as there is no blood band, she was referred to Baleswar district headquarter hospital for further treatment on record, though the duty doctor present namely Dr. A.K. Bhuyan was referred he neither tried nor assisted of a vehicle i.e., ambulance either 102 or 108 for taking the lady to district Hospital. The mother of the newborn baby was lying in the labour room and in the meantime two hours passed and finally, she died on the labour table at 7.15 PM on the same day.

Due to failure of the implementation and available services at each level Gouri Sasmal could not get benefits that are guaranteed under various schemes and delayed treatment deteriorated the health condition resulting her death. That as per the schemes implemented by the state opposite parties was not given to her at its required time period and has been deprived from.

ANC services have not been provided to Gouri Sasmal nor has she received the essential pre-natal entitlements under the National Maternity Benefit Scheme (NMBS) or services and post-delivery cash incentives under the JSY for institutional deliveries and the JSSK.

Maternal death can be defined as per the International Classification of Diseases (ICD) defines a maternal death as the death of a woman while pregnant or within 42 days of the end of the pregnancy, irrespective of the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (ICD 9th revision).

The chief protagonist in the petition is Gouri Sasmal and, the petition highlights the gaps in the implementation of schemes and programs that reduce maternal and infant deaths and the unsatisfactory state of implementation of the schemes for women during pregnancy and during childbirth, which led to her death. This petition is essentially about the protection and enforcement of the basic, fundamental and human right to life under Article 21 of the Constitution of India. This petition focus on two inalienable survival rights that form part of the right to life, the right to health (which would include the right to access and receive a minimum standard of treatment and care in public health facilities) and in particular the reproductive rights of the mother. The other right which calls for immediate protection and enforcement in the context of the poor is the right to food.

There is a system in place that is designed to provide adequate care for pregnant women in each of these villages, and yet they are not properly administered. This is a direct violation of multiple international agreements that India is a party to establish a right to survive pregnancy and childbirth. The government of India has created multiple schemes to provide services that guarantee a pregnant woman for that right. In this particular instances, there was a breakdown in the referral mechanisms which prevented antenatal care from being distributed, prevented the doctor from being able to understand his patient's condition when she arrived, and a failure of CHC, that could treat her in time. All of these resulted in a failure to avert a preventable maternal mortality, a violation of her right to survive during pregnancy and childbirth. The events of this case also constitute a violation of multiple rights provided by the constitution, including the fundamental right to health,

and guaranteed access to medical services regardless of status. Bhanumati Majhi especially, and the state failed to hold its employees accountable, she did not receive the care she needed to remain healthy during her pregnancy.

There is fear that other women similarly situated may face the same fate if the state does not address these egregious violations. The lack of oversight and accountability has created an environment rampant with failures that have finally resulted in maternal death. The CHC, ambulance services and DHH, Balasore all failed in their inability to respond quickly with services that could have saved this woman's life. Finally, but far from least importantly, if the ANM has regularly visited each pregnant women at the time of 3rd trimester, if the doctor had also taken prompt action in that period, it could have prevented the death of this woman. The need for corrective action in this district is blatantly obvious and needs to be taken immediately.

Under constitution there exists some guarantees and guidelines to which India is also a signatory, the right to survive pregnancy and childbirth is a basic human right. Under international law, India has a duty to ensure that women and infants do not experience death or morbidity from wholly preventable causes. This duty arises from multiple international conventions to which India is a party, and which establish the right to health, the right to reproductive autonomy, and the right to be free from degrading treatment. Relevant conventions include the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic Social and Cultural Rights (ICESCR), the convention on the elimination of All Forms of Discrimination against Women (CEDAWA), and the Convention on the Right of the Child (CRC).

Article 21 of the Constitution of India guarantees the right to life and personal liberty. The Hon'ble Supreme Court has interpreted Article 21 to include numerous fundamental rights already protected under international law, including a fundamental right to health (both physical and mental), the right to live with dignity and the right to be free from torture and cruel, inhuman, or degrading treatment. Article 14, 15 and 38 of the Constitution of India provide additional guarantees. Article 14 guarantees equality before the law, and the Hon'ble Supreme Court has described gender equality as one of the "most precious Fundamental Rights guaranteed by the Constitution of India." Article 15 prohibits discrimination on the grounds of religion, race, caste, sex or place of birth. While the burdens of pregnancy and childbirth are inequitably borne by women, the ability to reproduce should not increase women's chances of death, disability, or illness. Finally, Article 38 guarantees access to medical services regardless of status.

*Order***Date: 26/09/2016**

The aforesaid case was listed before the Hon'ble High court on 26.09.2016 for admission. During the course of hearing the Hon'ble High court, issued notice to all the opposite parties. Case is pending for final disposal.

Prayer

Under the facts and circumstances it is therefore humbly prayed that this Hon'ble Court may graciously be pleased to admit the writ application, issue notice to the Opp.Parties to show cause as to why the reliefs prayed for shall not be granted in favour of the petitioner and if the Opposite parties failed to show cause or showed insufficient causes, the Hon'ble court may further be pleased to issue direction to the Opposite Parties, to pass an order to reimburse petitioner for the expenditures incurred and provide a compensation of Rs. 10 lakhs for mental and physical trauma and for the upbringing Gouri Sasmal's loss and further be pleased to pass an order for Gouri Sasmal family to receive her financial entitlement under the National Maternity Benefit Scheme(NMBS) and to pass an order to pay Gouri Sasmal's family Rs. 20,0000 under NFBS. And may further pleased to pass such other order/orders, direction/directions may deem fit and proper in the interest of justice.

Relevant Cases

That the present case also relates to the order passed in the following cases:

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

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

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

In Paschim Bangal Khet Mazdoor Samity v. State of West Bengal, [1996 SCC(4) 37],

the Supreme Court affirmed that providing “adequate medical facilities for the people is an essential part” of the government’s obligation to “safeguard the right to life of every person.”

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

In *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors.* [W.P.(c) No. 8853/2008], the Delhi High Court held that an inalienable component of the right to life is “the right to health, which would include the right to access government health facilities and receive a minimum standard of care. In particular this would include the enforcement of the reproductive rights of the mother.”

In *Sandesh Babsal v. Union of India & Ors.*, [W.P.(C) No. 9061/2008], the Indore High court concluded that timely health care is of the essence for pregnant women to protect their fundamental rights to health and life as guaranteed under Article 21 of the Constitution of India.

Fact-finding conclusions

That a team comprising a health activist and social workers have conducted a fact-finding on the issue of death of the Gouri Sasmal, which clearly reveals that due to non-implementation of IPHS guidelines, non-implementation of NHM guidelines and non-available of services at the district headquarter hospital and due to medical negligence the patient died, for which the state authorities are solely responsible and are liable to be prosecuted as per law, as they have violated their code of conduct. It is also observed that even after the death of the patient; the medical authorities did not provide the transportation facility, while they are duty bound to provide the transport facility to her door step. Such callous actively of the Opp. Parties is not at all acceptable in a democratic country and such inhumane action violates the fundamental rights and constitutional rights of the people.

4. Sahab Uddin Mazumdar Vs. The State of Assam and 5 Ors. WP (C) 8645/ 2018

Synopsis

the petitioner is the husband of Laily Begum who died during her pregnancy. The petitioner has been taking care of their four minor children, all being girls and aged 3, 7, 13 and 16

years respectively. The petitioner belongs to the economically marginalized section of society and earns his livelihood through daily wage labour. The death of Laily was most unfortunate and has left him in grave mourning. Laily's death was caused by the negligence of the staff of Fulbari PHC in Cachar district of Assam. But there has not been any compensation provided to the petitioner and his family.

Facts

Petitioner had been married to Laily Begum for almost 17 years and had four children with her, all of them daughters. Laily was pregnant with their fifth child in 2016.

During pregnancy, according to the victim's Mother and Child Protection (MCP) Card, the victim had gone for three Antenatal Checkups, her hemoglobin was recorded as 10.9, 11 and 10 (gmdl) on each checkup.

The petitioner's wife died during pregnancy. The petitioner's wife was about 30 years old and the couple was expecting their 5th child. The victim started experiencing labour pain on 31/12/2016. In the evening at around 5 pm on that day, she was taken to the Fulbari Primary Health Center. The nurse present at the PHC then checked Laily and informed her and the Petitioner that the delivery will be conducted at 8 am on the next day, i.e. the 1st of January, 2017. Laily was admitted to Fulbari Primary Health Center and she remained there the whole night. Although Laily was in pain throughout the night but the doctor at the PHC never came to check Laily. There was one nurse present at the PHC during that entire night and she never raised an alarm about Laily's deteriorating condition. The petitioner was not allowed to go inside the female ward where Laily was kept. In the female ward, Laily's sister-in-law and her locality's Accredited Social Health Activist (ASHA) kept her company.

It was only at around 7 in the morning of 1st January, 2017 that the nurse informed the ASHA and the petitioner that the victim's health had significantly deteriorated over the night and she had to be taken to Silchar Medical College and Hospital. The distance between the two health centers is approximately 27 kilometres. Immediately then an ambulance was called for but it was engaged elsewhere then and took at least 45 minutes to reach. Unfortunately, by the time the ambulance had reached, Laily had breathed her last.

After Laily's death, there has not been any form of enquiry or investigation conducted to identify the reasons for the death. Neither any form of compensation has been granted to the petitioner's family for the clear negligence of the staff of Fulbari PHC that caused the death of Laily.

The Petitioner had filed a representation to the Joint Director of Health Services on 09/05/2018 seeking financial assistance and compensation for the death of his wife due to medical negligence. But he has not received any response to the representation till date.

Prayer

In the premises aforesaid, it is most respectfully prayed that your Lordships may be pleased to admit this petition and issue a Rule calling upon the Respondents to show cause as to why:

- (i) why a writ in the nature of the mandamus should not be issued directing the respondents to pay a compensation of Rupees Ten Lakhs (Rs. 10,00,000) to the petitioner and his family for the death of Laily Begum caused by the failure of the state public health system; and
- (ii) call for the records and upon hearing the parties be pleased to make the rule absolute. Pending disposal of the Rule, this Hon'ble Court be pleased to pass appropriate interim order directing the respondents:
 - (i) to pay an amount of Rupees Twenty Thousand to the petitioner under the National Family Benefit Scheme (NFBS); and
 - (ii) to conduct a community-based maternal death review of Laily Begum's death.

Order

11/ 01/ 2019

Heard Ms. Ghosh, learned counsel for the petitioner.

Issue Notice, returnable within 8 weeks.

Ms. A. Bora, learned Standing Counsel, Health Department, Assam accepts notice on behalf of respondents Nos. 1 to No. 4, Mr. M Nath, learned counsel for the panchayat and Rural Development Department, Assam accepts notice on behalf of respondent No. 5, Mr. D Das Barman, learned Government Advocate, Assam accepts notice on behalf of respondent No. 6.

Extra copies within 3 days.

List again on 25.03. 2019 showing the names of learned counsel for the parties.

5. Tikeram Bhoi Vs. Union of India & 5 Ors. 20992/ 2018

Synopsis

Tikeram Bhoi in this writ petition seeks to highlight the failure of state agencies in proper implementation of necessary provision of National Food security Act, and deficiencies in the implementation of schemes, meant for reduce maternal mortality and infant mortality funded by the Government of India implemented through Government of Odisha. The issues concern is the systemic failure, which has resulted in denial of benefit to Purnami Nil, during her pregnancy, under the Janani Suraksha Yojana (JSY), the Mamata Scheme, the National Family Benefit Scheme (NFBS) and the Integrated Child Development Schemes (ICDS) no such support provided to her. While she is legally entitled to get the benefits. Although the interrelatedness of these schemes was recognized by the Supreme Court way back in an order dated 28th November 2001 in Writ petition No. 196 of 2001 (People's Union for Civil Liberties v. Union of India, hereafter the PUCL Case and thereafter periodically orders by way of mandamus have been issued to the Union of India and the individual states, much remain to be done on the ground, as the case of Purnami Nial reveals, death of Purnami Nial death fits in to the internationally accepted definition of maternal death in terms of the period of death and the cause of death. The Purnami Nial died in the District Head Quarter Hospital, Nuapara, on 02.08.2018 during her treatment in the aforesaid Hospital.

Facts

Facts leading to file this case is that the wife of the petitioner was a pregnant lady. This is her first pregnancy. As per guide line her name has been registered under ICDS scheme, accordingly a Mother and Child Tracking System (MCTS) card has been issued in her favour which revealed that her expected date of delivery is 22.08.2018.

The petitioner humbly submits that on 01.08.2018 at early morning the wife of the petitioner health is not well and she stated vomiting, immediately the petitioner calls 108 Ambulance. After several request 108 Ambulance reach at about 09 AM immediately petitioner and his family rushed to District Head Quarter Hospital, Nuapara and Dr. Bhubaneswar Mishra check health condition of the petitioner wife and advised the petitioner to admit her wife and arrange a Blood. Those wives of the petitioner stay entire day but has not receive any emergency care and treatment. Next day i.e., 02.08.2018 early morning the

wife of the petitioner delivered a male child normally. After that the wife of the petitioner was unconscious. Nurse in duty called doctor and declare her dead.

In this case wife of the petitioner was the victim of negligence and insensitively shown by the entire system starting from the Sub- Health Centre, Community Health Centre and District Head Quarter Hospital to the unavailability of Medicinal and specialist's services resulting in his wife's death. The petitioner has filed this petition to ensure implementation of government schemes, to improve the conditions in government aided Hospitals and to obtained justice for Purnami Nial's family in the way of compensation and financial assistance.

As per the norms of the National Health Mission a pregnant women has to be provided antenatal services which includes two shots of tetanus injection, four checkups by the ANM, and nutritional support through the ICDS initiative at the village level. In the present case the wife of the petitioner was not covered under MAMATA Scheme which along with antenatal, post natal care and immunization also provides partial wage compensation (Rs. 1,500 in the sixth month of her pregnancy, and 1,500 after the completion of three month of the child), but here in this case even though the wife of petitioner covered under this scheme she had not get any incentive from the govt.

Despite there being a provision under National Health Mission free ambulance services that would facilitate the patients' movement from her home to the health services and then back to her home; but here in this case the petitioner has not get any facility as per the norms is clear violation article 14 & 21 of the constitution of India.

As per Indian Public Health Standard mentioned that every Community Health Centre should have equipped with Blood Bank facilities, Ultra Sonography Diagnostics Test Centre. Due to lake of the diagnostics test centre the wife of the petitioner travelled about 45 km in a risk condition to checkup her pregnancy. If the blood bank and doctors are available in the Community Health Centre, Khariar than precious life of the petitioner wife must be saved.

The government in the Centre has rolled out National Health Mission in all the states of India to attain universal access to equitable, affordable and quality health care services, accountable and responsive to the needs of the poor, with effective inter-sect-oral convergent action to address the wider social determinants of health. That the Government of India has initiated a strategic approach- Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) that embodies its vision for comprehensive and integrated health services, most importantly for adolescents, pregnant and lactating women, mothers and children.

There is a need to recognize neglectful, abusive and disrespectful treatment of Purnima Nial throughout the course of her pregnancy and also at the health facility. She was not provided adequate care and services when she reached the hospital, during her pregnancy. This demonstrates that mistreatment has occurred at the level of interaction between her and the service providers as well as through systemic failures at the health facility and health system levels.

Prayer

Under the facts and circumstances it is therefore humble prayed that the Hon'ble Court may graciously be pleased to admit the writ application, issue notice to the opposite parties to show cause as to why the reliefs prayed for shall not be granted in favour of the petitioner and if the opposite parties failed to show cause or showed insufficient cause, the Hon'ble court may further be pleased to issue direction to the opposite parties,

- i. To pass an order to set up an independent enquiry committee to review the medical negligence which resulted in the death of the petitioner wife.
- ii. To pass an order to reimburse petitioner for any expenditure incurred and provide a compensation of Rs. 2 lakh for mental and physical trauma and loss of her child.
- iii. To pass an order to ensure effective implementation of the guarantees in Janani Suraksha Yojana(JSY), Janani Sishu Surkhay Karyakrm (JSSK), Mamata Scheme and other benefits.

And may further pleased to pass such other order/orders, direction/directions may be deemed fit and proper in the interest of justice.

Order

The petitioner is stated to have filled a representation vide Annexure- 4 before the Collector-cum- Chairman, Zilla Swasthya Samiti, Nuapara- Opposite party No. 6 for redressal of her grievance. The said representation is stated to be still pending.

Taking into consideration the facts and submissions and without going into the merit of the case, the writ application is disposed of, directing the Collector- cum- chairman, Zilla Swasthya Samiti, Nuapara- Opposite Party No- 6, to dispose of the representation of the petitioner vide Annexure- 4 in within a period of two months from the date of receipt of a certified copy of this order.

The petitioner is directed to supply a copy of the writ application containing all the Annexures along with a certified copy of this order to the Opposite Party No. 6 for convenience and reference to Annexure- 4.

The writ application is accordingly disposed of.

6. Jaya Beshra Vs. Union of India WP No. 20993/ 2018

Synopsis

The petitioner, Jaya Beshra in this writ petition seeks to high light the failure of state agencies in proper implementation of necessary provision of National Food security Act, and deficiencies in the implementation of schemes, meant for reduce maternal mortality and infant mortality funded by the Government of India implemented through Government of Odisha. The issues concern is the systemic failure, which has resulted in denial of benefit to Ramani Beshra, during her pregnancy, under the Janani Suraksha Yojana (JSY), the Mamata Scheme, the National Family Benefit Scheme (NFBS) and the Integrated Child Development Schemes (ICDS) no such support provided to her. While she is legally entitled to get the benefits. Although the interrelatedness of these schemes was recognized by the Supreme Court way back in an order dated 28th November 2001 in Writ petition No. 196 of 2001 (People's Union for Civil Liberties v. Union of India, hereafter the PUCL Case and thereafter periodically orders by way of mandamus have been issued to the Union of India and the individual states, much remain to be done on the ground, as the case of Ramani Beshara reveals, death of Ramani Beshra death fits in to the internationally accepted definition of maternal death in terms of the period of death and the cause of death. The Ramani Beshra died in the District Head Quarter Hospital, Nuapara, on 20.03.2018 during treatment in the aforesaid Hospital.

Facts

The fact leading to file this case is that the petitioner was a pregnant lady. As per guide line her name has been registered under ICDS scheme, accordingly a Mother and Child Tracking System (MCTS) card has been issued in her favour on 22.02.2017 bearing MCTS card No. 121005783999 which revealed that her expected date of delivery is 26.08.2017.

The petitioner humbly submits that on 20.03.2018 at early morning the wife of the petitioner felt labor pain, therefore, immediately family members tried to contact ambulance

service provided by the Govt., 102 Ambulance reached at about 10 am immediately his family rushed to Community Health Centre, Sinapali but ASHA worker decided to take his wife to Community Health Centre, Khariar and admitted her. It is pertinent to mentioned here that even though the wife of the petitioner admitted at Community Health Centre, Khariar at about 11. 45 am but no single doctor was attained her, more than 8 hours she stay their without any medicine. At about 7.00 PM doctor checkup her health and refer to District Head Quarter Hospital, Nuapara. When they reach the Hospital the family member call the doctor, the doctor come and declare her dead.

In this case wife of the petitioner was the victim of negligence and insensitively shown by the entire system starting from the Sub- Health Centre, Community Health Centre and District Head Quarter Hospital to the unavailability of Medicinal and specialist's services resulting in his wife's death. The petitioner has filed this petition to ensure implementation of government schemes, to improve the conditions in government aided Hospitals and to obtained justice for Ramani Beshra's family in the way of compensation and financial assistance.

As per the norms of the National Health Mission a pregnant women has to be provided antenatal services which includes two shots of tetanus injection, four checkups by the ANM, and nutritional support through the ICDS initiative at the village level. In the present case the wife of the petitioner was not covered under MAMATA Scheme which along with antenatal, post natal care and immunization also provides partial wage compensation (Rs. 1,500 in the sixth month of her pregnancy, and 1,500 after the completion of three month of the child), but here in this case even though the wife of petitioner covered under this scheme she had not get any incentive from the govt.

Despite there being a provision under National Health Mission free ambulance services that would facilitate the patients' movement from her home to the health services and then back to her home; but here in this case the petitioner has not get any facility as per the norms is clear violation article 14 & 21 of the constitution of India.

As per Indian Public Health Standard mentioned that every Community Health Centre should have equipped with Blood Bank facilities, Ultra Sonography Diagnostics Test Centre. Due to lake of the diagnostics test centre the wife of the petitioner travelled about 45 km in a risk condition to checkup her pregnancy. If the blood bank and doctors are available in the Community Health Centre, Khariar than precious life of the petitioner wife and baby of the petitioner must be saved.

The government in the Centre has rolled out National Health Mission in all the states

of India to attain universal access to equitable, affordable and quality health care services, accountable and responsive to the needs of the poor, with effective inter-sect-oral convergent action to address the wider social determinants of health. That the Government of India has initiated a strategic approach- Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) that embodies its vision for comprehensive and integrated health services, most importantly for adolescents, pregnant and lactating women, mothers and children.

There is a need to recognize neglectful, abusive and disrespectful treatment of Ramani Beshra throughout the course of her pregnancy and also at the health facility. She was not provided adequate care and services when she reached the hospital, during her pregnancy. This demonstrates that mistreatment has occurred at the level of interaction between her and the service providers as well as through systemic failures at the health facility and health system levels.

The programme created a tiered healthcare delivery system to guarantee, inter- alia, maternal and child health services to all communities and imposed legal obligations on each entity to provide services such as those outlined below.

i. Sub Health Centre (SHC) of Sub centre:-

Should have at least one auxiliary nurse midwife (ANM), one male health worker (HW), four beds with mattresses, a fully equipped labour room with table, a fully equipped Newborn Care Corner, specific equipment for the sterilization of medical instruments and various supplies and medicines, available.

Early registration of all pregnancies, ideally within the first trimester,

Minimum of four antenatal check-ups: first visit to the antenatal clinic as soon as pregnancy is assumed, second between the fourth and sixth month (at around 26 weeks), and the fourth and ninth month (at around 36 weeks)

Associated general services, such as the measurement of weight and blood pressure:

Provision of supplements including folic acid at the beginning of the first trimester and iron at the beginning of the second trimester;

Vaccines, including an injection for tetanus toxoid;

Treatment of anemia;

Malaria prophylaxis in malaria epidemic zones (such as Odisha);

Counseling and referral for Reproductive Track (RTIs) and Sexually Transmitted Infections (STIs);

Disseminating information about government incentive schemes;

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

A minimum of two postpartum home visits, the first within 48 hours of delivery, the second within 7-10 days post delivery.

Implementation of national health programmes, the Universal Immunization programme and Reproductive and Child Health Programme.

Organization of Village Health and Nutrition Day (VHND)

ii. Primary Healthy Centre (PHC):-

All services available at SHCs;

Should have staff of 13, including MBBS doctor who acts as Medical Officer (MO), a pharmacist, a laboratory technician, 3 ANMs, 2 health assistants, 2 multi-skilled workers and 1 sanitary worker cum watchman. In addition to SHC equipment, a laboratory, additional medicines, and a means of doing laundry should be available.

Implementation of the Janani Surakshya Yojana (JSY) scheme;

24-hours emergency care including institutional delivery services for both normal and assisted deliveries, and

Full coverage of maternal diseases/health conditions

Postnatal care including the initiation of early breastfeeding and two postpartum home visits at a minimum;

Range of family planning including transport either by PHC vehicle or hired vehicle for which funds will be provided by the Government.

Referral services including transport either by PHC vehicle or hired vehicle for which funds will be provided by the Government.

Accountability should be ensured by posting the Charter of Patients' Rights and having an active Rogi Kalyan Samiti (RKS) committee to monitor and seek to improve PHC services.

Community Health Centre's (CHC):-

All services available at PHCs;

Essential and emergency obstetrics, gynecological, pediatric, dental and AYUSH care;

Minimum staff of 46 persons, including 1 Block MO overseeing 5 specialists (general surgeon, physician, OBGYN, pediatrician and anesthetist), 1 dental surgeon, 2 general duty MBBS doctors, 1 AYUSH doctors, 10 staff nurses, 2 pharmacists, 2 laboratory technicians, 1 radiographer, 1 vaccine assistant and many more staff.

Full range of family planning services;

Safe abortion services;

Blood bank facility;

Essential laboratory services; and

Implementation of all National Health Programmes.

Janani Surakshya Yojana (JSY):-

A core component of the NRHM is the JSY Programme described as a:

“Safe motherhood intervention under the (NRHM) will be implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. [JSY} is being implemented in all states and UTs with special focus on low performing states. JSY is a 100% centrally sponsored scheme and it integrated cash assistances with delivery and post delivery care.”

Women in Odisha, which is a Low Performing State (LPS) are entitled to the following entitlements:

JSY BENEFIT FOR INSTITUTIONAL DELIVERIES						
(In Rupees)						
Rural			Urban			
Category of States	Assistance to mother	Assistance to ASHA	Total	Assistance to Mother	Assistance to ASHA	Total
LPA*	1400	600	2000	1000	400	1400

V. Mamata Scheme (Specific to Odisha):-

Applicable throughout the state in all 318 rural projects, Mamata is a conditional electronic cash transfer maternity benefit scheme aimed at curbing the high rates of maternal and infant mortality by promoting positive child and maternal health and nutrition practices. The Mamata scheme offers pregnant and lactating women aged 19 years and more financial incentives to complete their trimesters of pregnancy with adequate antenatal care.

Because Mamata payments are delivered by e-transfer, women are required to open bank accounts into which the funds can be deposited. Administratively, Anganwadi Workers (AWWs) are responsible for the submission of names of beneficiaries to their supervisors for the payments to be made.

Janani Shishu Surakhya Karyakram (JSSK):-

Though NRHM, the Government launched the JSSK scheme in June 2011 as a means of elimination out-of pockets expenses incurred by pregnant women and for sick newborns, many of whom die on account of poor access to health facilities. The scheme permits pregnant women who seek institutional delivery and sick newborns to enjoy the benefits of absolutely free care in all government health facilities until 30 days after birth.

These health services are available to all women who deliver in government health facilities, regardless of age, economic status, or the number of children they have. The services include delivery, medicines, consumables, essential diagnostics, blood transfusions, nutritious meals (up to 3 days for normal delivery patients, and 7 days for Caesarean section patients), free transportation to and from the facility, and the exemption from all user charges.

The petitioner submits that, wife of the petitioner being a poor woman, ANC services have not been provided to nor has she received the essential pre-natal entitlements under the National Maternity benefit Scheme (NMBS) or services and post – delivery cash incentives under the JSY for institutional deliveries and the JSSK.

Article 21 of the Constitution of India guarantees the right to life and personal liberty. The Hon'ble Supreme Court has interpreted Article 21 to include numerous fundamental rights already protected under international law, including a fundamental right to health (both physical and mental), the right to live with dignity and the right to be free from torture and cruel, inhuman, or degrading treatment. Article 14, 15 and 38 of the Constitution of India.

The petitioner submitted a representation before the Opposite Parties ventilating her grievances and non implementation of the schemes in its proper manner and prayed for compensation from the state but the state authorities are sitting silent over the representation and did not take any action.

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 Article 32 by this Court or by the High Court under Article 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 of its contravention. A claim in public law for compensation for contravention of human rights and fundamental freedoms, the protection of which is guaranteed 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 the purported exercise of their powers, and enforcement of the fundamental right is claimed by resort to the remedy in public law under the Constitution by recourse to Articles 32 and 226 of the Constitution.

The purpose of public law is not only to civilize public power but also to assure the citizens that they live under a legal system which aims to protect their interests and preserve their rights. Therefore, when the court moulds the relief by granting compensation in proceedings under Article 32 or 226 of the Constitution seeking enforcement or protection of fundamental rights, it does so under the public law by way of penalizing the wrongdoer and fixing the liability for the public wrong on the State which has failed in its public duty to protect the fundamental rights of the citizen.”

However, the action of the opposite parties in not finalizing the matter in spite of repeated approach amounts to callousness and irresponsibility of the Opposite parties for which the petitioner has been seriously prejudiced.

The petitioner therefore, finding no other speedy, efficacious and alternative remedy craves indulgence of the extra ordinary jurisdiction of this Hon’ble Court to interfere in the matter of greater interest of justice.

Prayer

Under the facts and circumstances it is therefore humble prayed that the Hon'ble Court may graciously be pleased to admit the writ application, issue notice to the opposite parties to show cause as to why the reliefs prayed for shall not be granted in favour of the petitioner and if the opposite parties failed to show cause or showed insufficient cause, the Hon'ble court may further be pleased to issue direction to the opposite parties,

- To pass an order to set up an independent enquiry committee to review the medical negligence which resulted in the death of the petitioner wife.
- To pass an order to reimburse petitioner for any expenditure incurred and provide a compensation of Rs. 2 lakh for mental and physical trauma and loss of her child.
- To pass an order to ensure effective implementation of the guarantees in Janani Suraksha Yojana(JSY), Janani Sishu Surkhay Karyakrm (JSSK), Mamata Scheme and other benefits.

And may further pleased to pass such other order/orders, direction/directions may be deem fit and proper in the interest of justice.

And for this act of kindness, the petitioner as in duty bound shall ever pray.

Order

30. 04. 2019

The petitioner is stated to have filed a representation vide Annexure- 4 Series before the Collector- Cum- Chairman, Zilla Swasthya Samiti, Nuapara- Opposite Party No. 6 for redressal of his grievance. The said representation is stated to be still pending.

Taking into consideration the facts and submissions and without going into the merit of the case, the writ application is disposed of, directing the Collector- cum- Chairman, Zilla Swasthya Samiti, Nuapara- Opposite party- 6, to dispose of the representation of the petitioner vide Annexure- 4 Series in within a period of two months from the date of receipt of a certified copy of this Order.

The petitioner is directed to supply a copy of the writ application containing all the Annexures along with a certified copy of this order to the opposite party No. 6 for convenience and reference to Annexure- 4.

This writ application is accordingly disposed of.

Violation of Maternal Health Rights

Maternal mortality is appraised through the Maternal Mortality Ratio (MMR) which is the number of maternal deaths per 1,00,000 live births.

In 2000, the United Nations (UN) Member States pledged to work towards a series of goals. They termed it as the Millennium Development Goals (MDGs). These goals were to be achieved by 2015. It included the target of a three-quarters reduction in the 1990 maternal mortality ratio (MMR). Though India's MMR has been decreasing, India was expected to reduce its MMR to 109 per 1,00,000 live births by 2015, but it failed to do so with its last recorded MMR standing at 174.¹

Maternal health is a matter of serious concern in India. In 1990, the MMR in India was as high as 556. With advancement in health services and improved access to health facilities, the MMR has been gradually declining and now stands at 174. We are still some distance away from an ideal situation. In numbers, there were approximately 45,000 maternal deaths in India in 2015 which is about 15% of total maternal deaths in the world in that year. In addition, India and Nigeria together are estimated to account for over one-third of all maternal deaths worldwide in 2015.²

A number of schemes have been introduced and implemented like the Janani Suraksha Yojana, National Maternity Benefit Scheme and the Janani Shishu Suraksha Karyakram under the overall umbrella of the National Health Mission to improve the maternal health situation in the country. But the seriousness of Government's efforts can be legitimately questioned, when we observe that only 4.7% of the country's GDP is spent on health. To

1. WHO 2015, Trends in Maternal Mortality: 1990 to 2015

2. WHO 2015, Trends in Maternal Mortality: 1990 to 2015

compare, advanced countries like Germany and France spend more than 10 percent of their GDP on healthcare.³

Implementation Of Schemes and Entitlements

India is a country with the highest Maternal Mortality Rate and Neo-Natal Mortality Rate, for which promotion of Institutional delivery becomes one of the important interventions in India. A Nation-wide survey reports 73% institutional deliveries in the year 2009. Important reasons for home deliveries documented were lack of felt need for delivery at health facility, and high cost of the hospital services in India⁴. Factors affecting care seeking include economic status, parental education and high out of pocket (OOP) expenditure in hospitalization, and lack of or unaffordable transport facilities.

The conditional cash transfer scheme, named *Janani Suraksha Yojana* (JSY)⁵ was introduced in India in the year 2005, with a strategy is to link cash assistance to institutional delivery. Due to JSY, institutional deliveries across the country have increased but with a few limitations such as high OOP expenditure especially for purchase of the drugs, and transport, incurred by families.

3. World Bank Data, Health Expenditure, total (% of GDP); <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>

4. Improving Access to Institutional Delivery through Janani Shishu Surakshya Karyakram: Evidence from Rural Haryana, North India; Indian Journal of Community Medicine; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5427865/> Accessed on 13th July 2018

5. The Janani Suraksha Yojana (JSY) is a centrally sponsored Scheme which is being implemented with the objective of reducing maternal and infant mortality by promoting institutional delivery among pregnant women. Under the JSY, eligible pregnant women are entitled for cash assistance irrespective of the age of mother and number of children for giving birth in a government or accredited private health facility. The scheme focuses on poor pregnant woman with a special dispensation for states that have low institutional delivery rates, namely, the states of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha, and Jammu and Kashmir. While these States have been named Low Performing States (LPS) under the scheme, the remaining States/UTs have been named High Performing States (HPS). The scheme also provides performance based incentives to women health volunteers known as ASHA (Accredited Social Health Activist) for promoting institutional delivery among pregnant women. Cash entitlement for different categories of mothers is as follows:

Factor	Low performing states	High performing states
Incentives in rural area		
Mothers package	Rs. 1400	Rs. 700
ASHAs package	Rs. 600	Nil
Incentives in urban areas		
Mothers package	Rs. 1000	Rs. 600
ASHAs package	Rs. 200	Nil
Order of delivery	All birth order	Up to two live birth

In the view of these limitations, Government of India introduced *Janani Shishu Suraksha Karyakram* (JSSK) scheme in June 2011. Under this scheme; delivery, caesarian section, drugs and consumables, diagnostics, diet during stay (up to 3 days for normal delivery and 7 days for caesarian section), provision of blood, and transport between home to health institution is provided free of cost. The cash less service benefits are also extended to the newborn till 30 days after birth.

The Court underlined in the **Laxmi Mandal vs Deen Dayal Hari Nager Hospital & Ors W.P. 8853/2008**, a complete failure of the public health system and failure in implementation of Government Schemes, including the National Maternity Benefit Scheme (NMBS), Integrated Child Development Scheme (ICDS) and Janani Soraksha Yojana (JSY) – a scheme designed to reduce maternal and neo-natal mortality by encouraging institutional delivery for poor pregnant women. This case reflected the critical situation of Shanti Devi who was living in poverty belonging to Scheduled Caste. She passed away as the result of being refused to adequate maternal healthcare despite the fact that she qualified for the free services under existing state-sponsored schemes. In 2008, Shanti Devi was forced to carry a dead fetus in her womb for five days after being denied medical treatment at several hospitals because her husband was unable to show a valid ration card for medical services, despite being qualified for one as they lived below the poverty line. On January 20, 2010, Shanti Devi died immediately after giving birth at home to a daughter who was two months premature without any medical attention. The High Court of Delhi found that there was a failure to properly implement the pre and post natal services which should have been available to her, it was stated that it was inappropriate to place the burden on the poor to prove their eligibility for health services; rather government should be facilitating their access to these essential services.

In this case Justice Muralidhar instructed the State of Haryana, to pay compensation of Rs 2.4 lakhs to the family of Shanti Devi who passed away during child birth. The Court found the Respondents in violation of Shanti Devi's right to life and health, reiterating that her death was preventable. This paved the way to demand the inalienable survival rights that form part of the right to life: the right to health (which would include the right to access and receive a minimum standard of treatment and care in public health facilities) and in particular the reproductive rights of the mother. The other right which calls for immediate protection and enforcement in the context of the poor is the right to food.

The significance of this case lies in the reflection of the gap that exists in India, and globally, between the existence of laws that protect women's economic and social rights and

implementation of domestic policies which make these rights accessible and meaningful. This case was compounded by the intersectional discrimination Shanti Devi experienced being a poor woman from a Scheduled Caste. India has one of the highest rates of maternal mortality in the world, despite its burgeoning economy and rural health initiative. The maternal mortality crisis in India is linked to the deep inequalities faced by women and improving the situation will require substantive fulfillment of women's right to health, equality and non-discrimination. Advocates who worked on this case believe the judgment was an important victory and that it will have major implications for health policy in India, where a maternal death occurs every five minutes.

In September 2017, the Central Government of India launched the Pradhan Mantri Matru Vandana Yojna (PMMVY) - rechristened Maternity Benefit Program - with the aim of incentivizing proper healthcare for pregnant and lactating women. It provides a total INR 6000 to women over 19 years of age for the pregnancy and live births of their first two children as well as compensation for wage loss occurred during this period.⁶ In February 2017, in collaboration with the UNFPA, the Indian Government launched Saathiya scheme which hopes to educate over 26 crore adolescents regarding matters of gender, sexuality, consent and abortion, among other things, through 1.6 lakh peer educators. The scheme hopes to correct common misconceptions regarding matters of sex in the society and normalise ideas of homosexuality and practicing safe sex.⁷

This is not the first time that the Government has launched a ambitious programs to combat problems which plague sexual and reproductive rights.⁸ However, persisting issues indicate that the governments schemes are poorly implemented and do not fully reach the intended beneficiaries. In a country as vast as India and with an incredibly diverse geography and population, the existing government machinery and bureaucratic systems regularly fail to deliver the promised benefits and entitlements to women in need. The reasons for the inefficiency and ineffectiveness of the government may be attributed to a lack of necessary accountability, the stubborn problem of corruption, lack of proper

6. India. Ministry of Women and Child Development. *Pradhan Mantri Matru Vandana Yojna (PMMVY) - Scheme Implementation Guidelines*. By Ministry of Women and Child Development. September 2017. Accessed January 25, 2018. http://www.wcd.nic.in/sites/default/files/PMMVY%20Scheme%20Implemetation%20Guidelines%20_0.pdf.

7. Bureau, Outlook Web. "Health Ministry's Saathiya Scheme To Educate Adolescents On Gender, Homosexuality And Abortion." <https://www.outlookindia.com/>. February 20, 2017. Accessed January 25, 2018. <https://www.outlookindia.com/website/story/health-ministrys-saathiya-scheme-to-educate-adolescents-on-gender-homosexuality-/298026>.

8. See section titled 'Legal Protections and Schemes in India', pg. , for a complete list of both Centre and State sponsored schemes.

monitoring of implementation of schemes and an incorrect allocation of incentives. Hence, despite presence of multiple schemes for the reproductive health rights of women, India continues to see a desperate lack of access to quality care and consequently, a high MMR as compared to other nations.

For instance, the above described PMMVY scheme is implemented entirely through Accredited Social Health Activists (ASHAs). However, there is a dire shortage of trained ASHAs and ASHA Facilitators in many rural areas of India. Arunachal Pradesh alone reports an urgent need for over 347 ASHA workers in 2016-17 for areas where no ASHAs are currently present.⁹ Even when available, ASHAs frequently lack the necessary training to deal with issues that may arise. Furthermore, they are forced to deal with a lot of red tape when it comes to receiving their incentives, and even then, they often never see the money they are entitled to. Consequently, in many cases, ASHAs do not provide the healthcare assistance that they should and do not adequately inform people of the benefits that they can avail. Often they do not even visit vast areas of the population and hence, people living there have no access to much needed reproductive health and choices counseling.

The cases mentioned below will give an understanding how Human Right Law Network challenges the poor implementation of the Schemes, Policies and Programs which leads to gross violation of Maternal Health Rights.

1. Bilkis & Anr versus Gov't of NCT of Delhi & Ors. W.P (C) 4200/2015

Synopsis

Human Rights Law Network filed a Writ Petition in 2015, when violation of the JSSK scheme was noticed. Maternal deaths/ Infant Deaths are increasing mostly due to poor implementation of the Government maternal health scheme, absence of ante-natal care, broken referral system and substandard medical treatment during delivery was challenged.

The Plea stated, Delay in seeking delivery care, a delay in reaching facilities, and a delay in receiving adequate care at facilities led to the death of Tabassum. The latest data shows that 50,000 women in India died from pregnancy related causes in 2013, or 137 women every day and six women every hour.

9. India. National Health Mission. *National Health Mission: State Program Implementation Programs (2017-18)*. By Government of Arunachal Pradesh. 2017. Accessed January 25, 2018. <http://nhm.gov.in/nrhm-in-state/state-program-implementation-plans-pips/arunachal-pradesh.html>

The plea stated that The World Health Organization reports that the 90 percent of maternal deaths are preventable if women have access to antenatal services, skilled delivery assistance, and post-natal care. The plea sought Rs.12 lakh compensation in a fixed deposit account in the name of Tabassum's son for violations of his mother's fundamental rights and to ensure his education and health.

The plea also sought direction to governments to ensure that no woman succumbs to a preventable maternal death in Delhi and the entitlements under the JSY be provided to women post-delivery.

NMBS be provided to all needful citizens 8-12 weeks prior to delivery, government fully implement the guarantees in Janani-Shishu Suraksha Karyakram (JSSK), all patients and their families are treated with respect and dignity, and appropriate compensation be provided to the victim and family when preventable maternal deaths happen due to callousness caused by government aide d or private hospitals.

Facts

Tabassum, who belonged to poor strata of society, and her baby died as a result of "poor implementation of government maternal health schemes, absence of ante-natal care, a broken referral system, and substandard medical treatment during delivery", alleged the plea. The woman who left behind a five year-old kid had registered her second pregnancy at the MCD dispensary in Jwala Puri, Delhi. Tabassum's labour pains began on February 6, 2015, in early morning, after which she was taken to the dispensary but there was no doctor on duty to attend her and her condition started worsening.

From the dispensary she was taken to the Guru Gobind Singh Hospital and the ambulance took one hour to reach the hospital. The hospital staff referred Tabassum to the Deen Dayal Upadhyay Hospital, saying they did not have adequate equipment required for the surgery. It took another 30 minutes for her to reach the DDU Hospital.

Tabassum's mother-in-law paid Rs.5, 000 for medicines and her son paid additional sums in clear violation of the Janani Shishu Suraksha Karyakaram (JSSK) which guarantees totally free delivery services for all women at all government facilities.

After the delivery of child, the Deen Dayal Upadhhyay Hospital staff did not provide Tabassum's family any information about the health condition of the baby or about Tabassum. Next morning, the baby died and the doctors did not inform the family of the cause of death. A day later, Tabassum's condition started deteriorating, and the doctors did

not inform the family about it either. She died on February 15. The plea said from 4 a.m. till 3 p.m. of February 6, Tabassum was “either travelling from one health facility to another or waiting for her treatment”, which had complicated her case.

Order

28. 04.2015

The copy of the order is as follows: The mother-in-law of late Tabassum who, apparently, died on account of not being given necessary health care by the concerned authorities. As a matter of fact, the baby delivered by late Tabassum also died because of lack of necessary medical care.

Several issues have been raised in the petition, including the violation of the directions contained in the judgement of this court dated 04.06.2010, and passed in WP(C) No. 8853 /2008, titled: Laxmi Mandal vs Deen Dayal Hari Nagar Hospital & Ors. W.P. (C) 4200/2015

Respondents will file an affidavit which will, inter alia, indicate the measures that require compliance as per the provisions of Janani Suraksha Yojana (JSY), Integrated Child Development Scheme (ICDS), National Maternity Benefit Scheme (NMBS), Antyodaya Anna Yojana (AAY), National Family Benefit Scheme (NFBS) and also refer to the directions contained in Laxmi Mandal case that remain outstanding to date.

Respondents- Govt. of NCT of Delhi and Central Government, in its affidavit, will advert to all hospitals which are under their respective charge. The affidavit will, similarly, indicate the measures which are taken care of as per the schemes and the judgement referred to above. The gaps, which obtain, will be highlighted. The reasons for the same will also be adverted to in their respective affidavits.

In addition, the respondents will also deal with the system of referral obtaining in government hospitals whereby patients, it appears (as in this case), are made to travel from one hospital to another to get requisite medical care.

Perusal of the writ petition would show that the petitioner has sought reimbursement of Rs. 10,000/- towards expenditure incurred under the JSY scheme. Govt. of NCT of Delhi, in the meanwhile, will examine as to whether petitioner no.1 is entitled to reimbursement. In case petitioner no.1 is found entitled to receive payment, the said amount will be remitted to her forthwith. This direction is being issued, as late Ms Tabassum has left behind a five year old child who, I am told, is being looked after by petitioner no.1

22.02.2018

The record shows that on 19.2.2016, Mr. Naushad Ahmed Khan had appeared for Government of NCT of Delhi (GNCTD). On that date, Mr. Khan had made a statement before this Court that a sum of Rs.20,000/- would be paid to the legal heirs of the deceased under the National Family Benefit Scheme (NFBS). The petitioner no.1 is a legal heir of the deceased. The deceased is, one, Ms. Tabassum.

Concededly, to date, GNCTD has not resiled from this position. 2. A sum of Rs.20,000/- , I am told, is required, for the upkeep of the deceased s child Master Sarfaraz, who is aged about seven years. 3. Furthermore, I am also informed that petitioner no. 1 i.e., Bilkis is the paternal grandmother Master of Sarfaraz, while petitioner no. 2 is a social activist. 4. In view of the above, respondent no.1, GNCTD is directed to pay a sum of Rs.20,000/- to petitioner no.1 before the next date of hearing, failing which the Secretary, Department Social Welfare will remain present in Court on the next date of hearing. 5. Renotify the matter on 19.3.2018.

Outcome

The Petition filed by Human Rights Law Network on behalf of the Petitioners. Taking strong note of the failure of the maternal health schemes, the Delhi High Court has sought to know from the central and Delhi governments the measures they have taken in this regard. The High Court issued notice to the central and Delhi governments asking them to indicate the measures they have taken on working such schemes and gaps in them, and to highlight the reasons for not properly implementing them.

Issuing notice to Delhi's Deen Dayal Upadhyay (DDU) Hospital and Guru Gobind Singh Hospital (GGSH), the court also asked them to file responses on the measures that require compliance. The hospitals have to indicate the measures that require compliance as per the provisions of Janani Suraksha Yojana (JSY), Integrated Child Development Scheme (ICDS), National Maternity Benefit Scheme (NMBS), Antyodaya Anna Yojana (AAY), National Family Benefit Scheme (NFBS)," said the court.

The government designed these schemes to reduce maternal and neo-natal mortality by encouraging institutional delivery for poor pregnant women and providing necessary health and medical care during the term.

2. Anthony Debbarma versus the State Of Tripura and Ors WP(C) (PIL) NO.13/2016

Synopsis

The petition noted that India accounts for the highest number of maternal deaths in the world and has a Maternal Mortality Rate (MMR) of 178 for every 1 lakhs live births. Six Indian women die every hour because they became pregnant and do not have access to healthcare. At least 80 per cent of India's maternal deaths could be prevented if women simply had access to essential maternal and basic health-care services.

According to the National Family Health Survey-4 (2015-16) for Tripura, just 69.1 per cent of pregnant women deliver in public health institutions and only 1.2 per cent women who deliver at home have access to skilled birth personnel. An overwhelming 98 per cent of home deliveries are conducted without assistance. Additionally, all (100 per cent) children born at home in Tripura miss out on the crucial visit to a health facility within 24 hours of their birth. Despite over more than ten years of the National Health Mission and myriad of maternal and child health schemes, the state has failed to provide full antenatal care to pregnant women in Tripura.

Out-of-pocket expenditures for antenatal care, delivery services, and post-natal check-ups constitute a major barrier to institutional delivery in Tripura. The NFHS-4 shows that women in Tripura regularly spend Rs 4,000 to Rs 7,000 per delivery in public facilities. The poorest women in Tripura cannot afford to deliver in government hospitals.

This petition noted that under Janani-Sishu Suraksha Karyakram (JSSK), both the pregnant women and also the women who deliver child as well as others covered under the scheme need not to bear expenses for diagnostics, medication, transportation etc. The central government had come up with JSSK to reduce maternal and infant mortality which was a goal of Reproductive and Child Health Programme under the National Rural Health Mission (NHRM).

This scheme envisages free and cashless services to pregnant women including normal deliveries and caesarean operations and also treatment of sick new born (up to 30 days after birth) in all Government health institutions across the State/Union Territory. Under the said scheme following are the free entitlement for pregnant women- (i) Free delivery (ii) Free caesarean section (iii) Free drugs and consumables (iv) Free diagnostics (Blood, Urine tests and Ultrasonography etc.) (v) Free diet during stay (up to 3 days for normal delivery

and 7 days for caesarean section) (vi) Free provision of blood (vii) Free transport from home to health institution, between health institutions in case of referral and drop back home.

However, the scheme is regularly getting violated in Tripura. Even though JSSK is aimed at eliminating the out-of-pocket expenditures, which are a major barrier to institutional delivery, the Tripura government's memorandums related to implementation of JSSK ask women to pay extra fees for care during pregnancy and delivery. "In addition to creating a financial barrier to institutional delivery, Tripura's JSSK policy places substantial administrative burdens on families who have to produce bills, receipts, and photocopies of driver's registrations to receive compensation for delivery-related expenses. Individual stories highlight the immense financial, bureaucratic, and emotional burdens women face in attempting to access JSSK benefits," the petition noted.

Facts

HRLN confirmed, through fact-finding missions in the state that although JSSK had been issued by the Union of India, the state of Tripura had not implemented it in letter and spirit. The team found several women who were admitted to state-run hospitals for delivery and yet were forced to spend their own money to buy medicines and other consumables which were supposed to be free under the JSSK scheme.

The petition argued that the state had thus violated the women's fundamental right to life, health, equality and freedom from discrimination and women's protection of access to medical services regardless of status.

It thus prayed to the court to direct the state to revise Tripura's JSSK policy to ensure free services and then, to publish information on the free JSSK entitlements. It also sought the court's direction to the state to create a 'grievance cell' where women who have been charged for healthcare and delivery can apply for reimbursements.

Orders

13/06/2017

The copy of the order is as follows:

This PIL is about directing the respondents to implement the Janani-Shishu Suraksha Karyakram (JSSK) in letter and spirit and to completely put an end to user fees for pregnant

women delivering in public health facilities of Tripura. The learned State Counsel draws our attention to the memorandum dated 28.12.2016 annexed to the additional affidavit filed on 12.06.2017 and submits that the clause therein which says that in no case there should be any need for mother to pay the driver and reimbursed later on; money is to be given to the driver by Health facility directly by cheque. According to him, those provisions have now taken care of the grievances of the petitioner. It may also be noted that under Clause 2.2 of the same memorandum, it has been stated as follows:-

“Drugs and Consumables: All required drugs and consumables for pregnant mother during ANC, INC and PNC are already included in State Essential Drug List (EDL) and made available completely free. In addition, unit cost of Rs. 500/- for normal delivery and Rs.1600/- for C-Section delivery as per WP(C)(PIL) NO.13/2016 estimated no. of ANC cases and Rs.200/- in case of sick infants is by and large provisioned to supplement incidental requirement only. It is an indicative allocation for calculation purpose. Only in exceptional case concerned Health facility may locally procure certain JSSK drugs and consumables from the above allotted funds as per procedure. In no case mothers or sick infants shall be allowed to procure the drugs and consumables and later be reimbursed. In case of local purchase to meet incidental- requirement of drugs & consumables, the same have to be uploaded into the SCMS portal.”

In response, the court directed the ‘State-respondents to implement in letter and spirit the clauses’ of the memorandum filed by the state.

Outcome

In response, the court directed the ‘State-respondents to implement in letter and spirit the clauses’ of the memorandum filed by the state.

3. K. Pradipkumar vs. Union of India & Ors. PIL No. 25 of 2015

Synopsis

In this case, the petitioner was not provided with the entitlements of Janani-Sishu Suraksha Karyakram (JSSK) during her pregnancy in Manipur.

Facts

In this case, under Janani-Sishu Suraksha Karyakram (JSSK) both the petitioner (pregnant

women) and also the women who delivers child as well as others covered under the scheme need not to bear expenses for diagnostics, medication, transportation etc. rather it is to be done entirely by the State Government but the State Government has put cap over it by limiting the expenses to be borne by it which is as follows:

- “-Drugs and consumable for normal deliveries -Rs. 350/-
- Diagnostics -Rs. 200/-
- Blood Transfusion (Optional) -Rs. 250/-
- Diet (3 days for normal delivery) -Rs. 100 per day
- Diet (7 days for C-Section) -Rs. 100 per day
- Referral Transport for mother and sick newborns -Rs. 1000/-.”

The said ceiling over the expenses the Government has been breaching the guidelines issued by the Central Government on whose behalf affidavit-in-opposition has been filed wherein the practice adopted by the State Government has been deprecated. Statement has been made to the effect that all the pregnant women delivering in public health institution normal or caesarean are entitled free treatment. Not only that their entitlement includes free drugs consumables, free diagnostics, free blood wherever required, during stay at public health centre for normal delivery or caesarean section.

Orders

27/2/2017

Today, when we call upon Mr. R.S. Reisang, learned senior G.A. to show the authority on the basis of which this ceiling has been fixed over the expenses to be borne by the State Government nothing could be placed.

It be stated that the Central Government came with a scheme known as Janani-Sishu Suraksha Karyakram (JSSK) for reducing the maternal and infant mortality which was taken to be a goal of Reproductive and Child Health Programme under the National Rural Health Mission (NHRM). Under the scheme known as Janani Suraksha Yojna (JSY) there was phenomenal growth of institutional deliveries with skilled attendance at birth so that women and new born can be saved from pregnancy related deaths. In spite of institutional delivery being increased significantly the families felt pinch of high cost required to be borne which deter pregnant women to go for institutionalize delivery rather prefers delivery

at home as a result of which there used to be more death of the mother and neonates. To tide over this a scheme known as Janani-Sishu Suraksha Karyakram (JSSK) was launched on 1st June, 2011 to ensure free services to the pregnant women and sick neonates accessing public health institutions. The said scheme envisages free and cashless services to pregnant women including normal deliveries and caesarean operations and also treatment of sick new born (up to 30 days after birth) in all Government health institutions across the State/ Union Territory. Under the said scheme following are the free entitlements for pregnant women- (i) Free delivery (ii) Free caesarean section (iii) Free drugs and consumables (iv) Free diagnostics (Blood, Urine tests and Ultrasonography etc.) (v) Free diet during stay (up to 3 days for normal delivery and 7 days for caesarean section) (vi) Free provision of blood (vii) Free transport from home to health institution, between health institutions in case of referral and drop back home. The entitlements for sick New born till 30 days after birth are as follows:

- i) Free and zero expenses treatment
- ii) Free drugs & consumables
- iii) Free diagnostics
- iv) Free provision of blood
- v) Free transport from home to health institution, between health institutions in case of referrals and drop back home.

Surprisingly as against the free entitlements under the scheme as aforesaid, the Government has put cap over it by limiting the expenses to be borne by the State to the extent given below:

- (1) Drugs and consumable for normal deliveries -Rs. 350/-
- (2) Diagnostics -Rs. 200/-
- (3) Blood Transfusion (Optional) -Rs. 250/-
- (4) Diet (3 days for normal delivery) -Rs. 100 per day
- (5) Diet (7 days for C-Section) -Rs. 100 per day
- (6) Referral Transport for mother and sick newborns -Rs. 1000/-

One would find that expenses to meet out the free entitlements is to be borne by the State Government but fund for it is made available by the Central Governments, still the State Government has put cap over it by limiting the expenses as has been shown above; meaning

thereby that the State Government would not be meeting expenses more than what has been shown above which is not only in derogation of the scheme launched by the Central Government rather it is beyond its competence / authority.

Under the circumstances, the respondents are hereby directed to ensure free entitlements, to the pregnant women and also new born, available under Janani-Sishu Suraksha Karyakram (JJSK).

Accordingly, this PIL stands disposed of.

Let a copy of this order be handed over to Mr. R.S. Reisang, learned senior G.A. appearing for the State and also learned counsel for the Union of India as well as to the counsel appearing for the petitioner.

4. Smt. Chanem Mossang Vs. The State of A.P & Ors, WP(C). NO 307 AP (2016)

Synopsis

In this case too, the petitioner was not provided with the entitlements of Janani-Sishu Suraksha Karyakram (JSSK) during her pregnancy in the State of Arunachal Pradesh.

Facts

The petitioner delivered a baby girl on 24-09-2015 and she was registered in PHC Kharsang for ante natal check up under National Rural Health Mission. She tried to claim the amount she will be getting under the maternity benefit scheme for lactating mother which she never received. She didn't receive also the benefits under JSSK and JSY scheme she was suppose to get.

Order

5-9-2016

The High Court of Arunachal Pradesh had ordered:

I dispose of the writ petition and order the directions:

1. The Child Development Project Officer, (CDPO) Changlang will pass an appropriate

order with regard to the representation dated 28-03-2016 (Annexure-B) regarding entitlement of the petitioner for one month with the date of receipt of a certified copy of this order and if the petitioner is entitled to Rs 10000, necessary steps would be taken by the respondents to pay her the amount within a period of three months.

2. The petitioner will be at liberty to file a representation before the Director of Health Services, Government of Arunachal Pradesh, Naharlagun, with regard to her claim of Rs 700 under JSY scheme and for reimbursement of out of pocket expenses under JSSK scheme and in the event of filing any such representation. The same shall be considered with a period of 15 days from the date of receipt of the representation and thereafter, if the petitioner is found entitled to the amount, as claimed for; the same shall be paid within a period of one month.

The writ petition does stand disposed off.

5. Mosenla Vs. The State of Nagaland & 8 Ors. W.P. (C) No. 252 (K) of 2018

Synopsis

The Petitioner prefers the present Writ Petition under Art. 226 of the Constitution of India for enforcement of her entitlement, by way of reimbursement of all expenditure incurred during delivery of her child at Imkongliba Memorial District Hospital, Mokokchung, under the Janani Shishu Suraksha Karyakram (JSSK), 2011 and conditional cash assistance benefit under the Janani Suraksha Yojana (JSY), 2005.

The petitioner is a permanent resident of the State of Nagaland. As a member of a Scheduled Tribe, she falls into a category, which guarantees her free entitlements from the government to support her delivery. And as such, she is entitled to all the rights, privilege and protections guaranteed by the constitution of India and the law for the time being in force. The petitioner comes in a category which needs the government's free entitlements to support her delivery.

Facts

The petitioner states herein that her last menstrual period (LMP) was sometime on 28.11.2017 and that the petitioner had her pregnancy registered under the CHC of Changtongya vide registration no 2012, on 22.01.2018 for her to avail the various maternal

benefit schemes envisaged under the National Health Mission through the scheme of Janani Shishu Suraksha Karyakaram and Janani Shishu Yojana, providing for zero expenses and free delivery services to all pregnant women and lactating mothers, and conditional cash benefits respectively.

The petitioner subsequently revisited for follow up on 05.03.2018. During this course of her Ante Natal Check up, the CHC did not have provision for ultra sound facility and only very limited diagnostic services could be made available to her, wherein, she had to incur an amount of INR2000 (approx).

The petitioner states that in the absence Gynaecologist, Surgeon and other required medical staff for providing Emergency Obstetric Medical Care (EmOC) at the CHC of Changtongya the patient was compelled to further carry out her Ante Natal Check up (ANC) from District Hospital of Mokokchung and visited there first on 17.04.2018, and subsequently on 15.05.2018, 12.06.2018, 10.07.2018, 14.08.2018, even in this case, the patient had to incur money from her pocket for availing the ANC services. Also, with the lack of ultrasound facility in the district hospital the same was conducted twice in a private clinic, "Poly Clinic". That during this entire period, she had to incur an amount of INR 4500 (approx) for her ANC test alone inclusive of drugs diagnostic test, ultrasound test and others.

The petitioner was issued a Mother and Child Protection Card (MCPC), which keeps a track and records of pregnant women, and for availing various maternal benefit scheme one such is the scheme under JSSK. That the petitioner states that though her MCPC card was issued, the concept and objectives of an Anganwadi Centre was alien to her for she was never apprised of the same. She has never had any visits from the Anganwadi worker, Anganwadi Helper, ASHA nor Health Workers who could help her in availing the maternal benefits scheme prior to her delivery and post delivery and also help her assist her during her delivery.

The petitioner states that the petitioner came to Dr. Imkongliba Memorial District Hospital (IMDH) under Mokokchung District for delivery of her 2nd child on 26th August, 2018 and her Caesarean Section was conducted on 27th August, 2018 and was discharged on 9th September, 2018.

On religiously following up with her ANC at Imkongliba Memorial District Hospital, Mokokchung she was admitted on 26.08.2018 for delivery of her second child. Thereafter on 27.08.2018 she delivered her baby through Caesarean section. The petitioner states that there was no referral services being provided to her from her home to the facility. They had to arrange for their own mode of transportation to reach the hospital.

For her delivery in IMDH, Mokokchung, including diagnostic charges, drugs and consumables, cost of stay in hospital, referral transport, C-section charges, procurement of medicines, operation theatre charges and all others, an overall amount of INR 60000 was incurred from the pocket of the patient. It is also to be stated that all the medical bills and receipts were not given during entire course of treatment and only few given could be secured.

The petitioner herein states that after her delivery through C-section she had to stay in the hospital for another 14 more days for the reason that on the seventh day when her stitch was to be removed complication arose for in few portion, her stitches started to bleed, and that required her to further stay in the hospital for another seven more days having to go through the process of re-stitching which additional had to be paid by the patient to pay for the same. It was also informed to the petitioner by the doctor that she will be requiring blood for her C-Section and was asked to arrange the same by herself, though the blood was not required later on. Thereafter, she was discharged on 09.08.2018

The petitioner states that the entitlements envisages under the JSY and JSSK could not be availed by her, infringing her of her maternal entitlements and violation of Article 21 under the Constitution of India. Under the JSY, she did not receive the conditional cash assistance of INR700, and under JSSK she only received an amount of INR 1000 as Ambulance fare, and nothing more of the entitlement envisaged under the JSSK scheme was made available.

The petitioner begs to state before this Hon'ble court that the huge amount spent for the delivery and also the respondents failing to implement the true intend and purpose of the guidelines under the scheme wrote a detailed representation letter to all the respondent parties for reimbursement, on account of money spent during her delivery which otherwise should have been free of cost under the JSSK scheme but till date there has been no reply nor response received on the representation letter sent.

With no response from Respondents, having no other alternative, for the life of the Petitioner is more precious than money; the Petitioner's family personally procured the amount of money incurred during the delivery of the child in the form of out of pocket expenditure.

Prayer

In view of the premises stated above, it is therefore, prayed that Your Lordships may graciously be pleased:-

- to admit this writ petition and issue Rule Nisi;
- For a writ of mandamus or any other writ, order or direction in the nature of

mandamus directing the Respondents to conduct an independent inquiry to find out the cause(s) of the violation of Janani Shishu Suraksha Karyakram (JSSK), 2011 scheme and Janani Suraksha Yojana (JSY), 2005, and take necessary action against concerned medical health care providers for their denial of the Petitioner's benefits under aforementioned schemes.

- to issue a writ of mandamus or any other appropriate writ, order or direction thereby directing the Respondents to give full and complete reimbursement of all expenses incurred during antenatal checkups (ANC) and institutional delivery, post delivery of child of the Petitioner, at government hospital under the Janani Shishu Suraksha Karyakram (JSSK), 2011;
- to issue a writ of mandamus or any other appropriate writ, order or direction thereby directing the Respondents to provide cash assistance to the Petitioner under the Janani Suraksha Yojana (JSY), 2005;
- to issue a writ of mandamus or any other appropriate writ, order or direction thereby directing the Respondents to pay INR200000 (Two lakhs only) each separately as compensation to the Petitioner for mental agony and loss and injury suffered by her as a result of negligence and non-implementation of JSY and JSSK effectively by the Respondents;
- to issue any other/further order/ writ/directions, which the Hon'ble court may deem fit and proper in the facts and circumstances of the case.

Orders

09/ 04/ 2019

The prayer is allowed. List the matter after 3 weeks.

6. Rashmina Begum Vs. The State of Nagaland WP (C) No. 2013 (K)/ 2018

Synopsis

The petitioner is claiming for release of the benefits, which she is entitled as a mother under the Janani Shishu Suraksha Karyakram (JSSK) and Janani Suraksha Yojna (JSY) Schemes, under which pregnant women and children after delivery are entitled to certain benefits.

The petitioner is a permanent resident of the State of Nagaland. As a member of a Scheduled Tribe, she falls into a category, which guarantees her free entitlements from the government to support her delivery. And as such, she is entitled to all the rights, privilege and protections guaranteed by the constitution of India and the law for the time being in force. The petitioner comes in a category which needs the government's free entitlements to support her delivery.

Order

18/ 02/ 2018

In this petition, the petitioner is claiming for release of the benefits, which she is entitled as a mother under the Janani Shishu Suraksha Karyakram (JSSK) and Janani Suraksha Yojna (JSY) Schemes, under which pregnant women and children after delivery are entitled to certain benefits. Under the said Schemes, the Government of Nagaland also issued a notification on 14. 05. 2012, notifying the entitlements of the pregnant women and the sick new born till 30 days after birth.

As regards entitlements of pregnant women, following entitlements have been listed.

- Free and Zero expense delivery and C-Section
- Free essential drugs and consumables
- Free Essential diagnostics
- Free diet during stay in the health institution
- Free provision of safe blood (wherever blood banks/ blood storage unit exist)
- Referral transport assistance from home to nearest health institution providing the relevant services
- Referral transport assistance between facilities to nearest health institution providing the relevant service in case of referral
- Referral transport assistance for drop back from health institution to home after 48 hrs stay
- Exemption from all kinds of user charges

Further as regards, the sick new born till 30 (thirty) days after birth, the following entitlements have also listed.

- Free and zero expenses treatment
- Free essential drugs and consumables

- Free essential diagnostics
- Free provision of safe blood (wherever blood banks/ blood storage unit exist)
- Referral transport assistance from home to nearest health institution providing the relevant services
- Referral transport assistance between facilities to nearest health institution providing the relevant service in case of referral
- Referral transport assistance for drop back from health institution to home after 48 hrs stay
- Exemption from all kinds of user charges

The petitioner had given birth to a child on 17. 07. 2018. In connection with the delivery of the child, the petitioner had incurred more than Rs. 35,000/-. In that connection, the petitioner submitted a detail representation to the authorities claiming for grant of the aforesaid benefits under the said scheme on 11.10.2018 as a reminder to the earlier representation dated 19. 07. 2018. In spite of her representations to the authorities as indicated above, there has been no response following which the petitioner has approached this court by filling this petition.

Quality of Care in Health Care Services



The picture reflects the condition of the Community Health Center (CHC) of Rayagada, Kalyansinghpur Block, Odisha. The woman had come to the CHC for delivery and she was made to lie down on a bed without mattress whereas packed mattresses are seen lying without being used.

1. PAJHRA vs. State of Assam & Others, PIL 21/2012

Synopsis

The Gauhati High Court has just issued sweeping orders to the State of Assam to improve health services on tea estates. Recognizing the serious human rights violations on estates, the High Court held, “The reliefs sought are absolutely necessary to meet the health needs of the workers of the tea gardens... The State authorities are directed to comply the scheme as prayed in the writ petition within six months.”¹⁰

At 390 deaths for every 100,000 live births, Assam’s maternal mortality ratio is the highest in India. Maternal mortality represents a grave violation of women’s rights to life, health, dignity, and equality. As a part of a wider litigation strategy on maternal mortality, HRLN teamed with PAJHRA (Promotion and Advancement of Justice, Harmony and Rights for Adivasi rights) to hold the State accountable for violations and to demand changes in Assam’s tea estates.

An initial HRLN-PAJHRA fact-finding mission surveyed 6 Tea-Estate Hospitals, 1 village and 2 Primary Health Centers and uncovered the following fundamental rights violations:

- For every facility visited a single doctor treated between 25-300 patients per day
- Of the 9 facilities visited, 3 hospitals did not have a doctor
- Of the 9 facilities visited, 3 hospitals had no electricity. One facility conducted deliveries by candlelight
- The only blood bank in the district is housed at Tezpur District Hospital, located 32 kms from Rangapara PHC
- The team also observed that ambulances available at Tea Gardens Hospitals are rarely used and the management is reluctant to allow the use of the vehicle for all patients

10. Human Rights Law Network; Gauhati High Court Orders State of Assam to Ensure Tea Estate Workers’ Right to Health in Promotion and Advancement of Justice, Harmony and Rights for Adivasis (PAJHRA) vs. State of Assam (June 2015); <http://www.hrln.org/hrln/reproductive-rights/pils-a-cases/1702-gauhati-high-court-orders-state-of-assam-to-ensure-tea-estate-workers-right-to-health-in-promotion-and-advancement-of-justice-harmony-and-rights-for-adivasis-pajhra-vs-state-of-assam-june-2015.html> Last Accessed on 16. 08.2018

11. Vora, Kranti S., Dileep V. Mavalankar, Kv Ramani, Mudita Upadhyaya, Bharati Sharma, Sharad Iyengar, Vikram Gupta, and Kirti Iyengar. “Maternal Health Situation in India: A Case Study.” *Journal of Health, Population and Nutrition* 27, no. 2 (2009). doi:10.3329/jhpn.v27i2.3363.

12. Government of India. Ministry of Health and Family Welfare. “Health Secretary launches ‘SAATHIYA’ Resource Kit and ‘SAATHIYA SALAH’ Mobile App for Adolescents.” News release, February 20, 2017. Press Information Bureau. Accessed January 25, 2018. <http://pib.nic.in/newsite/PrintRelease.aspx?relid=158578>;

- From January to June 2011 three women died for pregnancy-related causes in Kalabeel and four cases of maternal and infant death occurred in Amlonga in 2010

Based on these rampant failures to implement the National Health Mission guarantees, to ensure women's Constitutionally guaranteed rights, and to uphold international legal protections, PAJHRA filed a Public Interest Litigation in the Gauhati High Court in 2012 (PIL 21/2012). In Promotion and Advancement of Justice, Harmony, and Rights of Adivasis (PAJHRA) v. State of Assam, the Court issued an order mandating the Assam government to supervise the implementation of the National Rural Health Mission's health care provisions. After the High Court disposed of the matter, HRLN and PAJHRA filed a Special Leave Petition in the Supreme Court to address maternal mortality in Assam and to hold the State accountable for violations and to demand changes in the Assam's Tea Estates.

Facts

This PIL underscores the lack of proper health care and facilities in Assam. The State of Assam holds the highest MMR of any major state in the country—a staggering 390 deaths per 100,000 births, compared to the national average of 212. The fact-finding team found rampant violations of women's reproductive rights including the denial of safe abortion services, the absence of blood banks and labour rooms, and inadequate staffing and bedding at all levels of medical and health facilities.

Order

29.05. 2015

Throughout the legal process HRLN and PAJHRA continued to visit the tea estates to document maternal deaths and inadequate health services. After a trip to the Supreme Court in 2012, the case returned to the Gauhati High Court in 2015. In May 2015, the Hon'ble Chief Justice (Acting) Mr. K. Sreedhar Rao and Hon'ble Mr Justice P.K. Saikia directed state authorities to make broad changes in tea estates to improve staffing, guarantee emergency obstetric care, ensure safe abortions, and install blood storage facilities.

A copy of the order is as follows:

“For an order directing respondents to immediately implement the NRHM in the TEs

bound by the MoU according to NRHM norms. Specifically, to ensure adequate facilities are set up in order to deliver NRHM service guarantees, including but not limited to emergency obstetrical care, access to safe abortion services, timely and adequate referral system and access to a functioning blood bank.

For an order mandating development and implementation of a time-bound Plan of Action for implementation of NRHM services as established under the MoUs.

For an order directing Respondent to immediately ensure the appointment of sufficient number of doctors, health professionals and support staff that are available 24 hours and 7 days at Tea Gardens' Hospitals as well as at each level- PHC, CHC, SHC, and DH- of health institutions in Sonitpur district.

For an order directing the establishment of a better transport system linking Tea Gardens with Government Hospitals and PHCs with sub-centers. Transportation must be free and not dependent on employment status. Ambulances must be available outside the hospitals and ambulance must not be subjected to the decision of the doctor but promptly guaranteed without delay.

For an order directing an audit and quality control review of all health facilities be done in Sonitpur district by third party Commission including representative from civil society appointed by the Court. Further to make publicly available the findings of the Audit and the action taken on these findings.

For an order directing the establishment of an efficient and transparent mechanism to review and monitor the implementation and delivery of NRHM services, in particular the expenditure of Government funds received by TE's management under the MoU. Monitor mechanisms must avail of, inter alia, conditions of health infrastructure, quality of care provided, organisation of awareness raising camps, use of ambulance service.

For an order directing the Respondents to collect disaggregated health and nutritional data on TE workers' and their families.

For an order directing respondents to introduce NRHM in all Tea Estates of Assam through mandatory MoUs between Tea Estates and the State Government.”

2. Geeta Postsang Vs. State of Manipur & 3 Ors, PIL NO 21 OF 2016

Synopsis

In this case the petitioners bring out the deficiency of sub-centres maintaining the hospitals

standards under the Indian Public Health Standard guidelines given by the National Rural Health Mission.

Facts

In this PIL, the petitioner has raised very disturbing issues which would adversely affect the Health Care System in the State. The petitioner has pointed out certain deficiencies in the functioning of Primary Health Sub-Centres.

Orders

31-07-2017

As many as 22 PILs have been taken up highlighting the various alleged deficiencies either by way of lack of proper infrastructure or man-power in various Public Health Centres/Sub-Centres/Primary Health Centres and Community Health Centres located in various parts of the State.

Since the State Government has not admitted to these deficiencies which have been highlighted in these PILs, we are of the view that samples survey of the functioning of these Public Health Centres/Sub-Centres/Primary Health Centres and Community Health Centres may help in deciding the issues raised in these PILs.

Accordingly, having obtained consent from the learned members of the Bar, a Committee of lawyers will be formed who will visit the various Centres/Sub-Centres located in all the District and submit a report before this Court by examining the issues. For this the following members of the Bar are appointed as proposed, for visiting the respective areas as mentioned below.

1. UKHRUL AND KAMJONG DISTRICTS.

- I) Mr. Mark Khapai (Advocate)
- II) Mr. Aaron Keishing (Advocate)

III) Mr. PhokmiRephung (Advocate)

2. CHANDEL AND TENGNUPAL DISTRICTS.

- I) Mr. Rebirthson (Advocate)
- II) Mr. SaimondLanghu (Advocate)

3. TAMENGLONG AND NONEY DISTRICTS.

- I) Mr. Ag. Chingkhiugong (Advocate)

II) Mr. Julius Riamei (Advocate)

III) Mr. K.R Pamei (Advocate)

4. CHURACHANDPUR AND PHERZAWAL DISTRICTS.

I) Mr. B.R. Sharma (Advocate)

II) Ms. Joan Kipgen (Advocate)

5. SENAPATI AND KANGPOKPI DISTRICTS.

I) Mr. Adani Kamuo Mao (Advocate)

II) Mr. R.S. Livingstone (Advocate)

III) Mr. KamminthangKhongsai (Advocate)

6. IMPHAL EAST, IMPHAL WEST, THOUBAL AND BISHNUPUR DISTRICTS

I) Mr. N. Jotendro (learned senior counsel)

II) Mr. M. Rarry (Advocate)

The Committee may decide the Public Health Centres/Sub-Centres/Primary Health Centres and Community Health Centres to be visited and the Committee may submit the report by 30thAugust, 2017 after visiting these.

In this regard, we call upon the State Government to pay a sum of Rs. 5000/- each to the learned members of the Committee as a token honourarium. The respective District authorities are directed to co-operate with the visit of the members of the Committee which may be intimated to the District authorities in advance so that the District authorities may render all necessary help to the visiting learned Committee.

Copies of this order may be furnished to Commissioner/Secretary (Health), Director of Health & Medical Officers/Chief Medical Officers of all the districts for necessary assistance and co-operation for the visit by the Committee members. The concerned district DMOs/CMOs may also arrange conveyance for the visit of the members of the Committee to the Centres/Sub-Centres.

Copies of this order may also be furnished to all the counsel for the parties as well as their members of the Committee.

The report, if possible should be submitted along with the photographs of the conditions of the said Centres.

List the matter again on 30thAugust, 2017.

3. Dusa Yama vs. State of A.P and 3 Ors. PIL 06 AP (2016)

Synopsis

In this case the petitioners have filed cases on the IPHS standards of the hospitals and the services provided by the hospital in the State of Arunachal Pradesh.

Facts

The petitioner has alleged that despite the availability of the requisite funds under the JSSK and JSY under the National Health Mission the state Government has failed to take proper steps for implementation as a result of which pregnant women and lactating mothers have denied of the basic amenities to which they are entitled under the scheme.

Orders

07-07-2017

- i) The honourable Court gave discretion that the Departmental Commissioner may constitute a team of competent Health Officials from the Health Department of State:
- ii) The aforesaid team may conduct physical administration of all the District Hospitals, PHCs and CHCs and thereafter, submit a fact finding report to the Government indicating the present status of the amenities and basic facilities available therein.
- iii) Based on such report, The Govt. would initiate proper action so as to ensure that adequate medical & healthcare facilities are made available in all the District Hospitals, CHCs PHCs within the State.

The exercise is directed by the Court to be carried out within a period of six months from the date of receipt from the copy of the order.

A copy of the fact finding report so prepared be furnished, free of cost, to the petitioners if an application is made by them, to that effect.

Considering the seriousness of the issues involved in these proceedings, this Court expects that the State Govt. will treat the matter with utmost seriousness and with top priority.

With the above observations, this writ petition stands disposed of.

4. Alin Mahanta vs. State of Assam & Ors, PIL NO 118 of 2015

Synopsis

In this case the petitioners have filed cases on the IPHS standards of the hospitals and the services provided by the hospital in Sonitpur which is one of the most backward and underprivileged districts in Assam.

Facts

This Public Interest Litigation has been filed by the petitioner-Miss Alin Mahanta-stating inter-alia that Kanaklata Civil Hospital, situated at Sonitpur District of Assam has no basic infrastructure to provide adequate treatment to the patients. A fact-finding team consisting of social activists and lawyers conducted a survey in the said hospital on 01/03/2015 and found that pregnant women, who came for delivery, were lying in the floors of the hospital due to shortage of beds. The said hospital is a 200 bedded hospital, but considering the frequency of the patients, the same is too meager and there was no move from the state government to augment the same. Only 35 beds were allotted to the maternity ward although it should have been 50.

Besides, other facilities such as ambulance, staff nurses, gynecologists, radiologists, surgeons, pediatrician etc. are not adequate. It has also been contended that the rate of deliveries carried out in the said hospital in a day is much higher than what the hospital could accommodate. According to the Indian Primary Health Standard (IPHS, in short hereinafter) the hospital should not have cracked walls, those should be free from seepage, there must not be any broken window, pans etc., but they said standards are not seen to have been maintained in the said hospital. Besides, there is no Intensive Care Unit (ICU) in the hospital and only 5(five) beds are there in the labor room, which is inadequate. Therefore, appropriate natal and post-natal facilities are lacking in the said hospital causing infringement of the Fundamental Rights of the people at large especially the women from the lower strata of the society as guaranteed under Article 21 of the Constitution of India, and hence it has been prayed that manpower in the said hospital may be enhanced as well as facilities may be provided as per the IPHS guidelines, ambulance services may be increased and a review of the maternal deaths in the district may be conducted.

Order

This Public Interest Litigation has been filed by the petitioner-Miss Alin Mahanta-stating inter-alia that Kanaklata Civil Hospital, situated at Sonitpur District of Assam has no basic infrastructure to provide adequate treatment to the patients. A fact-finding team consisting of social activists and lawyers conducted a survey in the said hospital on 01/03/2015 and found that pregnant women, who came for delivery, were lying in the floors of the hospital due to shortage of beds. The said hospital is a 200 bedded hospital, but considering the frequency of the patients, the same is too meager and there was no move from the state government to augment the same. Only 35 beds were allotted to the maternity ward although it should have been 50. Besides, other facilities such as ambulance, staff nurses, gynecologists, radiologists, surgeons, pediatrician etc. are not adequate. It has also been contended that the rate of deliveries carried out in the said hospital in a day is much higher than what the hospital could accommodate. According to the Indian Primary Health Standard (IPHS, in short hereinafter) the hospital should not have cracked walls, those should be free from seepage, there must not be any broken window, pans etc., but the said standards are not seen to have been maintained in the said hospital. Besides, there is no Intensive Care Unit (ICU) in the hospital and only 5(five) beds are there in the labor room, which is inadequate. Therefore, appropriate natal and post-natal facilities are lacking in the said hospital causing infringement of the Fundamental Rights of the people at large especially the women from the lower strata of the society as guaranteed under Article 21 of the Constitution of India, and hence it has been prayed that manpower in the said hospital may be enhanced as well as facilities may be provided as per the IPHS guidelines, ambulance services may be increased and a review of the maternal deaths in the district may be conducted. The respondent no.2-Commissioner and Secretary to the Government of Assam, Department of Health and Family Welfare, has filed affidavit-in-opposition stating that various government schemes for family planning and benefiting the mothers and their babies have been widely implemented in the said hospital without any discrimination, whatsoever. It has also been stated that the government has enacted the Assam public Health Act, 2010 to provide for protection and fulfillment of rights in relation to health and well-being of the public at large and as such every endeavor has been made to safeguard the interest of the people. It has been stoutly denied that proper hygiene is not maintained in the said hospital and on the contrary, it has been stated that regular treatments are being rendered to both the indoor and outdoor patients and surgeries, too, are being carried out successfully. Considering the rush of people, the numbers of beds have been increased to 263 from the earlier 200 beds, out of which, 81 beds have been exclusively allotted to the

Obstetrics and Gynecology Ward. Repair and renovation works have very recently been carried out and the IPHS Guidelines have been strictly adhered to, in the said hospital. Besides, the number of nurses allotted duty in the Obstetrics and Gynecology Ward are also apportioned as per the said Guidelines. Further, the ambulance services are provided for transporting pregnant women by means of 108 and 102 ambulance services and they are also transported to their respective homes after delivery by 'Adarani' ambulances. Besides, there is facility for round the clock institutional delivery and other allied services. The petitioner has stated in the affidavit-in-reply that during a subsequent visit by a team on 04/09/2016 it was found that the maternity ward was too crowded and there was shortage of beds and there was shortage of other medical facilities too. However, it has not been denied that the numbers of beds have been increased, facilities under various Government Schemes have been implemented, cash delivery assistance has been provided to the mothers etc. Upon hearing the learned counsel for the parties and upon perusal of the records, we are of the view that the Government has been making reasonable and sufficient endeavor to provide the basic facilities to the needy. Various welfare schemes especially for the welfare of the pregnant women have been implemented as far as possible. They have been provided with ambulance facilities whenever needed and have been also provided with cash delivery assistance. Further, the repair and renovation works also reported to have been done in the hospital recently. However, the authorities are required to review the same regularly so that proper hygiene is maintained. No doubt, with the increase of population in the nearby area and patients frequenting the hospital, the beds and other facilities are bound to be increased. We hope and expect that the respondent authorities shall make every endeavor to increase the same adequately. The respondent authorities have stated that the IPHS Guidelines have been strictly adhered to in the said hospital and the State Government will soon be appointing Radiologist, Dermatologist and Orthopedic Surgeon in the hospital. The authorities are, therefore, directed to monitor/review the same periodically and adhere to the IPHS Guidelines strictly for providing better facility to the poor and needy. We also direct the State Government to appoint Radiologist, Dermatologist and Orthopedic Surgeon in the hospital within 45 (forty five) days from today. With the above observations, the instant Public Interest Litigation is disposed of.

The Registry shall supply a copy of this order to Sri D. Saikia, Senior Additional Advocate General, Assam, for information and compliance. No order as to costs. The Registry shall supply a copy of this order to Sri D. Saikia, Senior Additional Advocate General, Assam, for information and compliance number order as to costs.

5. Alin Mahanta Vs. The State of Assam and 5 Ors. PIL 12/ 2016

Synopsis

The petition filed in public interest raising a grievance that the Government Hospitals in Baksa district do not possess the services of Blood Bank.

Order

20.05. 2019

Heard Ms. D. Ghosh, learned counsel for the petitioner. Also heard Mr. D. Saikia, learned senior counsel assisted by Ms. A. Das, learned counsel for respondent No.1 to 4; Mr. A. Talukdar, learned Standing Counsel, BTC for respondent No.5 and Mr. S. Sarma, learned senior Central Government Counsel for respondent No.6. The petitioner is before this Court in this petition filed in public interest raising a grievance that the Government Hospitals in Baksa district do not possess the services of Blood Bank. In that light it is contended that the same had led to other situations which had resulted in the post-delivery deaths. During the pendency of the instant petition, the matter has been pursued by the Government and steps have been taken to establish a Blood Bank. When the matter is taken up for consideration today, the learned senior counsel representing the State respondents has made available to this Court a copy of the licence issued by the Central Licensing Approving Authority to the Drugs Controller, Assam permitting to operate the blood bank for collection, storage and processing. Since at an earlier point it had been brought on record that Blood Bank had been established and the functioning of the same was awaited subject to issuance of licence, presently the entire process has been completed and the Blood Bank would be operational. In that view, the main grievance as raised in the instant petition has been answered and in so far as the other issues raised in the instant petition, they are ancillary to the fact that the Blood Bank has not been established. However, since at present the Blood Bank has been established, it would not be proper for us to go into the other aspects of the matter. However, if any other issue is subsequently raised, liberty is reserved to the petitioner and to any other litigants to approach this Court. In terms of the above, the petition stands disposed of.

6. Mr. J. Hillson Angam Vs. State of Manipur & 4 Ors. PIL No. 10 of 2018

Synopsis

This is a Writ Petition under Article 226 of the Constitution of India for issuance of a Writ in the nature of Mandamus or any other appropriate writ or order or direction thereby directing the

Respondents to ensure adequate supply of Blood in all the District Hospitals, Community Health Centres (CHCs), Primary Health Centres (PHCs) and Primary Health Sub-Centres (PHSCs) by setting up Blood Bank or Blood Storage Units at all the District Hospitals in the State of Manipur.

There are five Blood Banks in the State of Manipur i.e. (i) RIMSHospital, (ii) Thoubal District Hospital, (iii) Shija Hospital, (iv) Churachandpur District Hospital and (v) JNIMS Hospital. The total quantity of blood collected by the five Blood Banks for the year 2016 to 2017 was 62, 688 units, out of which the total quantity of Blood wastage was about 5499 units. While a large quantity of Blood/Blood components are being wasted by these Blood Banks, on the other hand, various District Hospitals in the State of Manipur do not have adequate supply of blood and as such, during emergencies the patients at such hospitals are made to suffer, rendering their lives in peril. Out of 16 districts of Manipur, 4 districts i.e. Churachandpur, Imphal West, Imphal East and Thoubal have Blood Banks and Bishnupur District Hospital has one Blood Storage Unit. Thus, health centres and hospitals located in 11 remaining districts of Manipur i.e.

Chandel, Senapati, Tamenglong, Ukhrul, Kangpokpi, Tengnoupal, Pherzawl, Noney, Kamjong, Jiribam and Kakching are operating without having Blood Banks or Blood Storage units. The Respondents purposed to establish 6 Blood Storage units at Tamenglong District Hospital, Bishnupur District Hospital, Ukhrul District Hospital, Senapati District Hospital, Chandel District Hospital and Moreh Sub-District Hospital. However, only one Blood Storage unit located at Bishnupur is operational so far. Thus, various District Hospitals are functioning without Blood Bank or Blood Storage unit. Indian Public Health Standard (I PHS) guideline stipulates that CHC, PHC, PHSC etc. are required to have Blood Storage unit connected to the mother Blood Bank but the said centres in the State of Manipur do not have Blood Storage units in violation of the IPHS guidelines.

Prayer

In view of the premises stated above, it is therefore, prayed that the Hon'ble Court may be graciously pleased:-

- i) to admit this writ petition and issue Rule *Nisi*;
- ii) to issue a writ in the nature of Mandamus directing the Respondents to ensure adequate supply of blood/availability of blood in all the District Hospitals by setting up Blood Banks at all the District Hospitals in the State of Manipur within a specific period of time;
- iii) to issue a writ in the nature of Mandamus directing the Respondents to set up Blood Storage units at all the Community Health Centres (CHCs), Primary Health Centres (PHCs) and Primary Health Sub-Centers (PHSCs) and ensure that all the Blood Storage units are functioning at the earliest;
- iv) in the interim to issue an appropriate order for constituting a high powered committee for investigating and preparing a report (a) on the demand for blood or its components for clinical use at various hospitals in the State, (b) the supply of blood or its components to the various hospitals in the State, the quantum of collection of blood by various blood banks, (c) the end use of blood/its components collected by the blood banks, (d) the prices at which blood or its components are made available by the blood banks and for all matters connected with distribution of the blood collected by blood banks;
- v) to issue any other appropriate order or direction which the Hon'ble court deems fit and proper in the facts and circumstances of the case. And for this act of kindness, your humble petitioner, as in duty bound, shall ever pray.

*Orders***12. 07. 2018**

This Public Interest Litigation is filed on the issue relating to establishment of Blood Banks in all the District Hospitals, Community Health Centres and Primary Health Centres and Primary Health Sub-Centres along with Blood Bank or Blood Storage Units in the District Hospitals in the State of Manipur.

The petitioner highlighted the condition of the present Blood Banks stating that it is in a very dismal condition and not being properly maintained and further goes on to plead that the Blood Banks have not been established in many of the District Hospitals and Community Health Centres and Primary Health Centres etc. There is a response filed by the

first and second respondents and the learned Advocate General states that steps have been taken to establish new Blood Banks. Considering the serious issue namely maintenance of proper Blood Bank for the benefit of victims, who may need emergency blood and to ensure the Blood Banks and the Blood Storage Units are properly maintained in hygienic condition.

The Advocate Commissioners have to inspect the various Blood Banks and report to this Court as to the condition of the Blood Banks and the manner in which they are maintained. The Director, Health Services, Manipur will depute a senior officer to go along with the Advocate Commissioners to inspect the Blood Banks and the Advocate Commissioners shall file a report after completion of the inspection with all the shortfalls or errors in maintenance of Blood Banks. Each Advocate Commissioners will be paid a sum of Rs.5000/- as remuneration by the State Health Services Department with proof to be submitted before this Court. List the matter after filing of the report of the Advocate Commissioners on 20-08-2018. All assistance to be given by the Health Department to the Advocate Commissioners without any demur. Copy of this order be furnished to the learned A.G. and counsel for the petitioner and Advocate Commissioners.

Respectful and Dignified Care



The condition of the Rayagada District Hospital is alarming as they have a set up of 80-90 beds for the patients but more than 200 patients gets admitted every day.

1. Madhav Lal vs. State of Madhya Pradesh W.P No. 3071/2017

Synopsis

This petition talks about multiple violations of rights of a pregnant women and how the mishap could have been avoided. This is a case of clear negligence due to which the twins whom Mamta gave birth to under the Peepal tree near the District Hospital of Morar, passed away as it was a pre-matured birth. There are several other cases happening every day in different parts of India and an infant is dying due to utter medical negligence.

Facts

Mamta, 27 years old at 11:30 pm was taken to CHC Malanpur, Gohar Tehsil, Bhind District, where (ANM) Nirmal Gohar had checked her and found that she needs a premature delivery at seventh month. She was further referred to Morar District Hospital at 11:55 pm. Dr. Sadhna Pandey, Nurse Usha Tomar, Kalavai, Mangla, were in-duty. Hem Singh interacted with the Doctor to admit his wife Mamta. But, unfortunately, Mamta was not allowed to enter the hospital and was kicked out of the hospital. The staffs' in-charge used abusive and foul languages by pointing out the caste of Hem Singh and his wife. This was a serious case as the delivery was a pre-mature and had its own level of complications. After the incident with the hospital staffs they took shelter near a Peepal Tree near the hospital gate and she delivered the infant there out in the open.

Due to this negligent attitude of the doctors, nurses and other staff Mamta was compelled to deliver under a tree just outside the hospital. After struggling for long Mamta finally gave birth to two live twins (boy and girl). But sadly they couldn't survive because it was premature delivery that required doctors' assistance and the protective environment of a hospital. They didn't deserve to die on the road like this. Due to non availability of medical care twins died, then after also she was not admitted in the hospital. After frustration her husband dialed 101 and was admitted into the hospital on 26-04-17 to 29-04-17 she was admitted into the Morar District Hospital. After her admission she was not treated properly and no medicines were given to her. After her discharge facility of Janni express was not given to her and she had to pay Rs.300 from her pocket. According to the Janani Suraksha she did not receive the benefit of Rs. 1400/.

That is a case of failure of sterilization Mamta got her sterilization on 11/12/2010 at CHC Gohar. Due to failure of NSV she was pregnant after 6 years. In another incident Ramabai

wife of Suresh Jatav, residents of Shanichar village, Gwalior, also happened to deliver outside the hospital due to the negligent and indifferent attitude of the doctors, nurses and other staff at the hospital. In this instance, even after 22 minutes of delivery Ramabai kept lying in the open / without any assistance from hospital staff in a life threatening situation. It was only after the ambulance driver took her inside the hospital on stretcher the hospital authorities took note of it and admitted her immediately. That the patient suffered and lost their life due to non-implementation of The Indian Medical Council/(Professional Conduct, Etiquette & Ethics) Regulations, in its true spirit and mandate.

Relevant Laws

Chameli Singh vs. State of U.P. [(1996) 2 SCC549] that: “the right to shelter is a fundamental right available to every citizen and it was read into Article 21 of the Constitution of India as encompassing within its ambit, the right to shelter to make the right to life more meaningful, saying, “In any organized Society, right to live as a human being is not ensured by meeting only the animal need of man. It is secured only when he is assured of all facilities to develop himself and is freed from restrictions, which inhibit his growth. All human rights are designed to achieve this object. Right to life guaranteed in any civilized society implies the right to food, water, decent environment, education, medical care and shelter. These are basic human rights known to any civilized society. All civil, political, social and cultural rights enshrined in the Universal Declaration of Human Rights and Convention or under the Constitution of India cannot be exercised without these basic human rights”.

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

Sandesh Bansal vs. Union of India & Ors., [W.P.(C) 9061/2008] the Hon’ble Madhya Pradesh (Jabalpur Bench) High Court concluded that timely health care for pregnant women is essential to protect their fundamental rights to health and life as guaranteed under Article 21 of the Constitution of India. The Court held, “..[w]e observe from the material on record that there is shortage not only of the infrastructure but of the man power also which has adversely affected the effective implementation of the [National Rural Health Mission] which in turn is costing the life of infants and mothers in the course of mothering. It should be remembered hat the inability of women and child to survive

pregnancy and childbirth violates her fundamental rights as guaranteed under 61 events of this case also constitute violence of multiple rights provided by the constitution, including the fundamental right to health, and guaranteed access to medical services regardless of status and the state failed to hold its employees accountable, she did not receive the care she needed to remain healthy during her pregnancy.

Order

29.08.2017

Violation of Schemes under National Mission guaranteeing access to free maternal health services such as Janani Suraskha Yojna and Janani Sishu Surakhya Karyakram under the National Health Mission.

That Hon'ble Acting Chief Justice of M.P. high Court held in Sandesh Bansal Vs. UOI. W.P. No. 11860/13.

“It be remember that the inability of women to survive pregnancy and child birth violates her fundamental rights to live as guaranteed under Art. 21 of the constitution of India and it is the primary duty of the government to ensure that every woman survives.

Shri Amin Khan, learned counsel for the petitioner. Shri Praveen Newaskar, learned government advocate, for the respondent/ state.

By way of indulgence and in the interest of justice, further fifteen days' time is granted to file reply.

However, taking into consideration the fact that despite repeated opportunities granted to the respondent/ State reply has not been filed, time to file reply is granted subject to cost of Rs. 10,000/- (Rs. Ten Thousand Only) to be deposited with the society, namely, “ High Court of Madhya Pradesh Middle Income Group Legal Aid Society, 2015”. By the officer in charge of the case along with a certificate to the effect that aforesaid amount is being paid by him and not by the State exchequer. List the case in the week commencing 18th September 2017.

The case is on-going.

2. Shanti Devi and Anr. V. Safdarjung Hospital and Ors. W.P(C) 9499/2017

Synopsis

The Petitioner gave birth to a live baby at about 22 weeks gestation which was incorrectly declared dead by medical staff at birth. The baby when again presented before the medical staff was kept in ventilator & survived for about 36 hours.

Facts

Shanti Devi was admitted at Safdarjung hospital, New Delhi on dated 15.06.2017 delivered a prematurely baby on dated June 18, 2017. This baby was born at the 20+ week's gestation that was incorrectly declared dead by the medical staff present, immediately after its birth without any proper examination.

The medical team blatantly ignored the baby's movement and grasp of air which was also noticed by the father who brought it to the notice of the concerned medical staff. This plea was rejected by handing over the baby wrapped in a hard-packed paper (envelop) getting away from any responsibility by saying that "I am the medical expert here you are not." The father utterly confused took the baby home for last rites. Removing the paper envelop from the child **GRASP FOR AIR**. This act of the helpless child who was struggling to breathe is the very sign of life.

Overwhelmed, the father's only desire was to protect the life of the child so to enable infant to survive. After returning to the hospital the baby was put on oxygen and then on a ventilator, however the infant passed away on June 19, 2017 at 4.15pm after surviving for nearly 36 hours. The baby received inadequate medical treatment at birth leading to his suffering and possibly his death, violating various obligations under Indian and international law. Had he received adequate medical treatment it might have been possible he would have survived, despite his preterm birth.

This Petition relates to the medical negligence inflicted by the medical staff at Safdarjung Hospital, the lack of health care provided to the baby at birth and lack of health care provided to Shanti Devi, the mother of the infant, in the lead up to the birth of the child.

Shanti Devi had experienced heavy bleeding in her pregnancy one month prior to giving birth. On May 2017, she experienced loss of blood. She went to the dispensary in Badarpur

Border where she was then referred to Safdarjung Hospital. She was admitted there around 10:00 p.m. She was asked to get ultrasound done. With ultrasound report she approached again to the doctor where she was advised that the baby and naal was upside down and asked to get herself admitted. She got admitted there where she was asked for blood. During this period, the hospital asked Shanti to provide two bottles of blood so that she could have a blood transfusion. She was unable to provide the blood and consequently, morning she was told to return home, take proper rest, when the child starts playing inside, it will get stop on its own. However, she was not provided with any medication. They kept all the medical slip/documents with them. Bleeding was still going on.

Bleeding continued for around 15 days. Then on 09-06-2017 Shanti Devi has decided to visit to a private doctor in a nearby clinic named Getwell clinic. Again Ultrasound done there which costs her Rs 600/- and for consultation fee Rs. 600/- and advised that everything is normal and baby is doing well. He did not prescribe any medicine and advised to visit some big hospital.

On 14 June 2017, Shanti experienced further heavy bleeding. Her health deteriorated significantly with her body going 'pale'. She was taken to Safdarjung Hospital in an ambulance around 06:00 p.m. She was accompanied by her husband Rohit and sister-in-law Uttara. She was made to wait for around 4 hours in the maternity ward for her turn. There she was advised to get ultrasound done first. She got her ultrasound done, visited to the doctor again with the report where she was advised to get herself admitted and around 01:00 p.m. she was admitted to Ward No. 10 (labour room). She was there for three days. She was administered Glucose once. A lady doctor diagnosed her and advised that bleeding is still going on so it requires C-section as the baby and naal was upside down. She was told that bleeding will get stopped only when baby and naal will be taken out. For that she needed a blood transfusion. Her husband was asked to arrange blood.

It was very difficult for the father to arrange blood and therefore, requested to get it from the hospital itself. He was scolded by the lady doctor and told him that if you are not able to arrange blood then take your patient out as we cannot donate for you. Feeling helpless her husband requested his friends some of them were ready to donate. Two of them visited the hospital but they were asked by the medical staff to come in the morning as it is getting dark. Next morning he arranged for two people to donate but they were being refused by medical staff saying there is cut mark on the hand and other was of low weight.

When blood was not arranged her husband was forced to purchase blood when one person approached him that he can donate blood at the cost of Rs 3500/-. With no other

option Rohit has decided to purchase and thus he has given him Rs 2000/- but his blood was also not taken because of donor is amputated and asked to arrange for another donor. That donor did not return money to him.

Feeling helpless he approached to the blood bank of Safdarjung hospital. After requesting from blood bank officer there by her husband, finally he was allowed to get one unit of blood from blood bank of the hospital.

The doctor was unable to treat Shanti until she stopped bleeding. She was in hospital for two days before giving birth at 5.30 am on Sunday June 18, 2017. During 02:00 am. She was suffering from severe pain and cold. She approached to the ANM present there. The ANM scolded her and said that her delivery was not of full month so it's better to take rest. She was made to suffer with that pain for many hours waiting for morning to inform her husband around 05:00 am. Then she called her husband, who was resting outside the gynecology department in the hospital campus.

He informed the situation to the lady doctor who visited her. She was again scolded by the doctor by saying that her pregnancy is not mature enough to get deliver. Then the doctor left the room leaving her behind in pain and instructed her husband to shift her to the nearby room. Finally the birth happened around 05:30 a.m. on 18th of June, 2017 by normal delivery. Her husband rushed to call doctor to see her. The doctor (Archana) along with two ANMs came and saw the patient and the child. The doctor said that the baby is a boy, alive and of 460 gm. The doctor again shifted her to the labour room with the baby.

After 15 minutes the doctor came out along with the mother and the child. The mother was asked to take rest in another room and the baby was handed over to her husband in a wrapped paper envelop enclosed with a piece of cloth by saying that the child is dead. The father felt the movement in the body and he reported the same to the doctor. The doctor checked again and said that the child is no more. When requested again by her husband, the doctor scolded him by saying that she is the medical expert.

The father waited there for around one and half hour for the family members who were on their way when they heard about the incident. The whole family was in utter shock. He then took the baby home while the mother remained in hospital to receive additional treatment. Before performing last rites of the baby, his grandmother requested to see his face. Removing the paper envelop from the child, he **GRASP FOR AIR**. This act of the helpless child who was struggling to breathe is the very sign of life.

As soon as the family found that the baby was still alive. The family took video footage of the baby in which one can see that he is visibly breathing and moving.

After finding the baby alive, the family called 100 to report the hospital's negligence. They also called ambulance. However, the police from Badarpur police station met on the way to hospital. Police personnel stopped the ambulance and asked about the incident. The father told them that it is an emergency situation so he asked the police personnel to visit to hospital. At 10.30 am on 18 June, 2017 the family rushed the baby back to the hospital. They visited to the nearby Apollo hospital first where they were asked to deposit Rs. 40,000/- for the admission of the baby. The family found incapable to pay decided to go again to Safdarjung hospital.

From there they straight away went to emergency ward where the baby was kept in the open and was attended by the doctor who put the baby on oxygen mask through an inadequately sized mask. Then the baby shifted to Nursing Ward No.5 where he was put on ventilator.

As his another child named Avinash Kumar, 5year old, who was also admitted there in the hospital in Ward No. 20 because of some infection in liver. Her husband was there where he got a call that he needs to fill forms for admitting the child. Her husband got a call that he need to visit to doctor at ward no. 5, where new born baby was admitted. He visited there wait for more than one hour. He was asked to fill the form of admission for the new born baby in ward no. 5. After this he visited again to Warn no. 20 to see his younger child. He went again to ward no. 5 around 5:00 pm to see his new born child but no doctor met him. He got a call around 9:30 p.m. from a family member that on NEWS channel it is broadcasting that the child is dead. He was surprised that the hospital authority did not inform him about this. To verify this he called the hospital staff and asked about the same which was verified by them that the child is dead. Her husband approached twice to meet the child in ward no. 5 but he was denied to visit him.

The baby was alive for nearly 36 hours after being put on the ventilator. He passed away at 4.15pm on 19 June, 2017. The family was not informed that he had passed away. They were not given his body even after for the next 25 hours. Upon being heard that the hospital authority was not handing over the body, the whole family turned up at the hospital to get the body to perform last rites. They were told by the hospital authority that since it involves a police complaint so call the concerned I.O. (Rajender Singh, Badarpur Police Station) then only they will hand over the body and asked to complete the paper work formalities. The I.O. (Rajender Singh) has taken over the death certificate/ documents given by the

hospital authority. Upon being asked by the father about those documents, police refused to return by stating that it of no use for him.

Finally after completing all the formalities he was handed over the dead body around 05:30-06:00 pm for last rites. The hospital authority did not give any documents to him. The death certificate was taken away by the police personnel. When it was asked by her husband he was denied by saying that it is of no use to him.

She did not get discharge even after she got normalized in ward no. 10 which was told by one doctor. She was not get released for next two days by saying that doctor has not signed the discharge certificate so he has to wait for next day. By then two days has passed. As her husband said that his work is getting affected if they do not get her discharge he will call police and media. Only then they get ready to discharge her from the hospital.

As the incident was covered by various electronic and print media, the police personnel took her husband to the higher medical authority of the hospital where he reported about the medical negligence. The authority denied any medical negligence and asked that he is free to do whatever he wants to do. The authority also informed him that by doing any case this only he will get into trouble and no compensation will be given to him in this case. He said that her husband is free to go to the court of law.

To bear the expenses her husband borrowed money (Rs. 35,000/-) from his known on an interest rate of 10% per month. He lost his job for more than one month. The whole family was traumatized and mentally, physically disturbed for more than one month because of this incident.

On dated 1st July, 2017 a legal notice, on behalf of the petitioner, has been sent to Chief Medical Officer, Safdarjung Hospital, Delhi to know the reason cited for death through Head Ticket, Death certificate copy of ultrasound, infant death audit report etc.. In reply to this a letter received on dated 01.08.2017 wherein the information of which was denied by the Medical Record Department & Training Center (MRD & TC) requested to mention the purpose for getting the needful done and apply through Proper channel i.e through insurance company, if it is for insurance claim or through Court of Law, if it is for any Court case.

The present Writ Petition is being filed under Article 226 of the Constitution of India by the Petitioner No. 1 (Shanti Devi), who was admitted at Respondent No. 1 hospital (Safdarjung Hospital), New Delhi on 15.06.2017 and delivered a premature baby on 18.06.2017. This infant was born premature around the fifth month of pregnancy (the

expected delivery date was 22.10.2017) during the 22 weeks gestation and was erroneously declared dead by the medical staff on duty, immediately after its birth without proper examination. The medical team blatantly ignored the baby's movement and gasp of air which was noticed by the father & brought to the notice of the concerned medical staff but the staff on duty rejected the father's plea and handed over the infant wrapped in a hard-packed paper (envelope) and brusquely responded "I am the medical expert here, you are not." The father utterly confused took the infant home for its last rites but on removing the envelope for the last rites realized that the infant was still alive and gasping for air. The father immediately brought the live infant baby back to the Respondent No. 1 hospital to get appropriate medical facilities to enable the infant to survive & also informed the Delhi Police about the incident by dialing 100. Safdarjung hospital, at first put the infant on oxygen and then on ventilator. However the infant expired two days later on June 19, 2017 at 4.15pm after surviving for nearly 36 hours. The premature baby received inadequate medical treatment at birth leading to his suffering and possibly his death, violating various obligations under Indian and international law. Had he received adequate medical treatment it was possible that he would have survived, despite his preterm birth. This Petition relates to the gross medical negligence, the utter callousness and lack of empathy leading to lack of provision of health care to Petitioner No. 1, a poor pregnant woman and her new born infant by the medical staff at Respondent No. 1 Hospital, subsequently leading to the death of the infant. The newborn infant was alive for almost 36 hours after being put on life support. However the authorities of Respondent No. 1 Hospital refused to admit any medical negligence on their part and said that Petitioners were free to take any action against them as they were ready to face whatever the consequences be. The family had borrowed Rs. 35,000/- from a local money lender on an interest rate of 10% per month for Petitioner No. 1's medical treatment. The Petitioner No. 2 was out of his job for almost a month & has lost all his income. The whole family has been trying to get over the trauma, mental as well as financial.

A legal notice was sent to the, Respondent No. 1 Hospital, on 01.07.2017, on behalf of Petitioner No. 1 asking for the case history, death certificate, ultra-sound report, infant death audit report & other like documents of the Petitioner No. 1 & the deceased infant baby. In reply to the legal notice dated 11.07.2017 a formal communication dated 01.08.2017 was received from Respondent No. 1 hospital denying the request made in the legal notice & to approach the hospital for such information through a proper channel viz. through an insurance company or through the court of law.

*Orders***02.11.2017**

1. The petitioners have filed the present petition, *inter alia*, praying as under: - “a. Issue a writ of Mandamus or any other appropriate writ order or direction to the Respondents to constitute a independent committee to review the incident of gross medical negligence and address these shortcomings so that poor and impoverished women receive respectful and dignified care and the life of the infant and the mother is not put at risk.”
2. Issue notice returnable on 03.01.2018. Notice shall go to respondent no.1 by courier, without payment of process fee.
3. The averments made in the petition indicate that present case to be one of gross medical negligence. It is alleged that a new born infant was declared dead and handed over to the father of the child. It is stated in the petition that the father of the child pointed out that he felt that the child was alive and was attempting to breathe but the doctors insisted that the child had expired. It transpires that the child was alive and was subsequently brought back to the Hospital; the infant remained in the care of the hospital for a period of two days but could not be saved. The petitioners have also annexed certain photographs with the petition which shows the manner in which the child was handed over to his/her father; these photographs are disturbing to say the least. In view of the directions proposed to be given here under, this Court is refraining from making any adverse observations regarding the manner in which the child was handed over by the Hospital.
4. In these circumstances, this Court directs respondent no. 5 to constitute a committee of three senior officers to enquire the incident. The Committee would consist of Secretary, Health, Union of India or his nominee not below the rank of a Joint Secretary, Additional Director General Health Services, Union of India and the Medical Superintendent of RML Hospital.
5. The Committee so constituted shall submit a report after due enquiry into the incident. The said report be submitted within a period of eight weeks from today. The Committee would be at liberty to call any of staff/or doctors of respondent no.1 for the purposes of their inquiry and respondent no.1 and the concerned doctors/staff are directed to fully cooperate with the Committee and make themselves available as and when required.

6. Respondent no. 1 is directed to hand over the copies of all medical records available with the respondents to the petitioners. The Medical Superintendent of respondent no.1 shall also retain a copy of the same to be provided to the Committee as constituted above in addition to any further information that the Committee may require from respondent no.1.
7. The petitioners are at liberty to make a complaint to Delhi Medical Council for medical negligence.
8. List on 03.01.2018.
9. Order *dasti* under signatures of the Court Master.

03.01.2018

1. The learned counsel appearing for respondent no.1 submitted a report indicating that there was no medical negligence, as “no resuscitation was required in this case as the abortion was not compatible with any survival”.
2. The learned counsel appearing for the petitioners points out that the facts of this case are almost similar to the recent case of MAX Hospital, which was shut down by the concerned authorities as the hospital had returned baby/fetus declaring him/her to be dead, although, it later transpired that the fetus had some life. The learned counsel for the petitioners insists that the infant in that case was also delivered prematurely (approximately after five months of gestation period). In these circumstances, respondent no.2 is directed to produce the necessary records of the said case.
3. Clearly, the respondents cannot have two standards for medical treatment one for private hospital and the other for government hospital.
4. It was also noticed in the last order that the photographs annexed with the petition, which showed the manner in which the infant was handed over to his father were disturbing. At that stage, this Court had refrained from making any adverse observation in this regard considering that the directions were issued for constitution of a Committee to examine the matter. It is seen that the report submitted by the Committee does not consider the manner in which the fetus was handed over by the concerned authority.
5. It is not possible for this Court, after having viewed the photographs, to ignore the same. Respondent no.1 shall file an affidavit indicating as to the person responsible for handing over the fetus in the manner it was done and further indicating whether any

steps are proposed to be taken in this regard.

6. It is noticed that on the last date of hearing i.e. 02.11.2017, the Medical Superintendent of respondent no.1 was directed to ensure that the copy of medical records available with respondent no.1 be provided to the petitioner. The learned counsel for the petitioner states that the same has not been handed over. A final opportunity is granted to the concerned Medical Superintendent to do so within a period of one week from today. He is further cautioned that this Court will take a serious view if orders of the Court are not complied with.
7. List on 18.01.2018 for further proceedings.

22.03.2018

1. A request for accommodation is made on behalf of Ms. Monika Arora, who appears on behalf of UOI.
2. Learned counsel for the petitioners has taken me through a copy of undated inquiry report which appears to have been generated in and about December, 2017.
3. The conclusion and the recommendations of the inquiry committee after taking inputs of experts are as follows:

“Conclusion:

1. Technically by virtue of gestational age and weight the outcome of pregnancy in this case qualified to be an abortus and not a „baby and did not merit proactive resuscitation.
2. Resurgences of some signs of terminal gasps/flickers of movement in such an abortus on receiving some warmth is known as per expert opinion.
3. By all international/national standards no resuscitation was required in this case as the abortus at this age is not compatible with any survival.
4. Thus considering all the above points, there does not appear to be any medical negligence on the part of treating doctors and standard management guidelines have been followed.

Recommendations:

1. There should have been more open and transparent communication with the patient about the prognosis of abortus.

2. The committee appreciates the concerns and anxiety of the parents in such cases and recommends that the treating doctors should empathize with such parents and family members.
3. In doubtful cases opinion of experts should be taken, the parents should be kept informed about decision making and abortus should be handed over to the parents after complete satisfaction of the parents regarding cessation of life.”
4. Learned counsel for the petitioners says that the baby survived after it was handed over to the parents i.e., the petitioners for nearly thirty six (36) hours.
5. It is stated that the baby was handed over to the petitioners on 18.6.2017 and since it showed signs of life it was re-admitted in Safdarjung Hospital in the evening hours of 18.6.2018.
6. While this aspect requires examination, what requires to be looked as well, is whether respondent no.1/Safdarjung Hospital has a protocol in place to sensitize/ train doctors as how they should deal with the patient’s attendants and/ or their kith and kin. Respondent no.1/Safdarjung Hospital will place on record an affidavit if such a protocol is already in place.
7. Counsel for GNCTD says that the record of Max Hospital is available. Learned counsel is directed to bring the same to the Court on the next date of hearing.
8. Renotify the matter on 18.5.2018.

26. 11. 2018

Petitioner no.1 was admitted with respondent no.1 hospital on 15.06.2017 and delivered a premature fetus on 18.06.2017. The infant was born in the fifth month of the pregnancy. The fetus was declared dead and the body was handed over to petitioner no.1.

3. Petitioner no.2 (father) of the infant took home for last rites. However, found that the infant was still gasping for air. The infant was immediately bought back to respondent no.1 hospital and was put on oxygen. It is the petitioner s case that the infant, survives for 36 hours thereafter and finally expired on 4:15 PM on June 19, 2017.
4. Insofar as the petitioners prayer for seeking medical records is concerned, this Court by an order dated 02.11.2017 had directed that the same be handed over to the petitioners. Admittedly, the petitioners have received the records and the petitioner s grievance in this regard stands satisfied.

5. This Court had also directed that an independent enquiry be conducted with regard to the allegations made in the present petition. Pursuant to the aforesaid orders, a Committee was constituted by three senior officers (Dr A. K. Gadpayle, Addl. DGHS, Dte. GHS; Smt. Gayatri Mishra, Joint Secretary (Hospital), Ministry of Home and Family Welfare; and Dr V. K. Tiwari, Medical Superintendent, Dr RML Hospital, New Delhi). The said Committee also invited four other doctors as special invitees. The Committee examined the records as provided by respondent no.1 hospital. A copy of the report has been handed over to this Court.
6. The same, *inter alia*, indicates as under:-
 - “8. During conservative management, patient aborted a conceptus of 470 gms on 18.06.2017 spontaneously.
 9. Abortion is the expulsion or extraction from its mother of an embryo or fetus weighing 500 gms. or less when it is not capable of independent survival (WHO). The expelled embryo or fetus is called abortus. (Annexure II). The abortus was observed for 60 mins. (which is median survival rate for abortus below 20-22 Wks.) (Annexure VII) and handed over to relatives for last rites as there were no signs of life observed during this period.”
7. The Committee also concluded as under:-

“Conclusion:

1. Technically by virtue of gestational age and weight the outcome of pregnancy in this case qualifies to be an abortus and not a „baby and did not merit proactive resuscitation
2. Resurgences of some signs of terminal gasps/flickers of movement in such an abortus on receiving some warmth is known as per expert opinion. 3. By all international/international standards no resuscitation was required in this case as the abortus at this age is not compatible with any survival.
4. Thus considering all the above points, there does not appear to be any medical negligence on the part of treating doctors and standard management guidelines have been followed.”
8. It is relevant to note that the Committee also made certain recommendations, which are set out below:-

“Recommendations:

1. There should have been more open and transparent communication with the patient about the prognosis of abortus.
2. The committee appreciates the concerns and anxiety of the parents in such cases and recommends that the treating doctors should empathize with such parents and family members.
3. In doubtful cases opinion of experts should be taken, the parents should be kept informed about decision making and abortus should be handed over to the parents after complete satisfaction of the parents regarding cessation of life.”
9. The learned counsel appearing for the petitioner states that there are certain factual discrepancies as according to the petitioner the infant did survive for 36 hours. The learned counsel appearing for the petitioner also relies on the Death Summary furnished to the petitioner, in support of the aforesaid claim.
10. This Court is of the view that since the controversy in this regard involves disputed question of facts, it would not be apposite to examine the same in this petition.
11. In view of the above, the present petition is disposed of leaving it open for the petitioners to institute an appropriate action for compensation, if so advised.

3. Snehalata “Salenta” Singh v. State of Uttar Pradesh, High Court of Allahabad W.P. 14588/2009*Synopsis*

In *Snehalata “Salenta” Singh*, a woman named Snehalata Singh suffered a vaginal fistula as a result of extremely negligent treatment in a public facility during her labor. In the 10 months subsequent Salenta’s delivery, she was either repeatedly refused care, or provided with highly inadequate care. She filed suit, claiming that the medical negligence violated her rights to health and a dignified life.

Facts

Snehalata Singh is a poor brick kiln worker from Uttar Pradesh. Having previously given birth to five children naturally through a home birth, Snehalata gave birth to her sixth child

at the Purkaji Primary Health Center (PHC) in hopes of receiving a financial incentive from the government under the Janani Suraksha Yojana (JSY) scheme. Due to the improper treatment she received from an untrained ANM, she suffered a vaginal fistula – a hole in the bladder that causes the involuntary discharge of urine – rendering her incontinent. Additionally, PHC officials forced her husband to purchase her medication and extorted an illegal bribe from Snehalata and her husband to be discharged from the PHC.

She later returned to the PHC seeking treatment for the fistula, and was provided medicine without a thorough medical checkup. Ultimately, Snehalata visited eight different health centers before her condition was correctly treated through surgery. Snehalata was incorrectly diagnosed and treated for infection with antibiotics at many of the medical facilities she visited. In violation of government schemes mandating free health care for Below the Poverty Line (BPL) individuals, public health facilities refused to provide her with medication and surgical remedies due to her inability to pay. Snehalata sought help from an organization called the Health Watch Forum and received an operation only after their intervention. The operation was successful, but she continues to suffer from related injuries and persistent pain, and is thus unable to work. Along with Health Watch Forum, she filed a Writ Petition against the state of Uttar Pradesh, arguing that her rights to life, health, dignity, equality, and non-discrimination were violated.

Snehalata was seeking compensation for medical expenses as well as for physical and mental suffering. The petition also requests that the Court order the State to fully implement the healthcare guarantees of the NRHM for pre- and post-natal care, ensure effective referrals among health care providers, and monitor maternal deaths and provide compensation when necessary.

Relevant Law

Constitution: Articles 14 (right to equal protection), 15 (right to be free from discrimination) & 21 (right to a dignified life)

Statutes & Schemes: JSY, NRHM

Order

The Allahabad High Court finally delivered a damning judgment on the 9th March, 2018 after HRLN filed a petition on behalf of Snehalata. The PIL stated that the right to health has previously been held as an integral facet of the right to life under Article 21 of the

Indian Constitution. The Allahabad High Court agreed, and notably stated: *‘if in one word we have to describe the State medical services, it is quite apt to use the word for its functioning on its destiny and fate – “Ram Bharose”*

The judgment further directed among several things: increased vigilance in adhering to and inspecting hospital standards, unfilled vacancies of medical and paramedical staff and non availability of drugs and services in the hospitals to be addressed. The court further noted that *“huge funds are spent in the name of welfare medical services undertaken by State but fact is that those services are not available to real needy people but swelling pockets of those who are supposed to serve.”*

To fix this, the court directed the CAG to establish a specialized audit team, which, in different phases and periods, would audit medical colleges and hospitals within a year’s time and observe patterns of fund utilization, deficiencies and illegalities so that swift action can be taken against responsible authorities.

Further, taking note of the behaviour of government employees ‘who frequently avail better private medical services and claim reimbursement from the state exchequer’, the court said that “no special VIP treatment” would be given to anyone, including high-level officials, political executives and dignitaries, and asked them to avail medical services from government hospitals like every other citizen.

Highlights from the Allahabad High Court judgment included:

‘Inefficient, inadequate, improper, unclean and bad services at the level of PHC or additional PHC or above is mostly attended by poor people and they suffer all these odds. At the highest level namely medical colleges or KGMU or some specialized autonomous institution like Sanjay Gandhi Post Graduate Institute etc., people of status sometimes also visit, but, mostly, they manage their affairs by availing medical facilities in well equipped highly sophisticated and expensive private medical institutions and mostly reimbursement is made by Government. It is for this reason that the executives, whether bureaucrat or political, both, neither have a firsthand information about problems of public health service nor they care since they are not affected and those who mostly attend have no voice. They are weak, underprivileged, deprived and feel satisfied with whatever is made available to them. That is how they are also cheated, misused and exploited in the hands of scrupulous lower staff as we have seen in the present case where ANM demanded illegal gratification from petitioner-1.’

‘We could not understand huge unspent fund and reason therefore. No one is taking care to explain reason for such unspent funds when services are in such a bad shape. Moreover, wherever

funds are spent, still facilities are lacking and it also needs explanation. In our view, it is a case of sheer negligence, lack of supervision and non accountability which is persisting the problem. We do not want to lengthen our judgment with voluminous observations since things are self speaking and process of improvement also needs a large scale scrutiny at various level. Much more and serious steps need be taken at different levels we need real dedicated and devoted people to be appointed to serve needy person.'

Outcome

This judgment was significant as it not only reprimanded the individual circumstances that led to Snehalata's condition, but delivered a damning verdict on the whole state healthcare system of Uttar Pradesh. Of particular importance was the emphasis placed on delivering a decent quality of care regardless of economic status, with the Court criticizing the apathy of bureaucrats who themselves avail private healthcare, ignoring the issues faced by the masses who they claim to represent.

4. Pooja Sharma and Anr. Vs. Kasturba Hospital and Ors. W.P.(C) 6499/2018 and CM No. 24897/2018

Synopsis

The present Writ Petition is being filed under Article 226 of the Constitution of India by the Petitioners, seeking immediate medical attention & relief to Petitioner No. 1 to undergo PAC for Stoma Closure as advised by the doctor at Respondent no. 2 Hospital which was denied or allegedly postponed for the last two visits.

Petitioner no. 1 was suspected of SAIO (Subacute Intestinal Obstruction) post C-section delivery at Respondent no. 1 hospital and referred to Respondent no. 2 hospital. After diagnosis it was found that a 'mop' measuring 25*20 cm was left in the stomach of Petitioner no. 1 negligently by the attending doctors during C-section delivery on 03.02.2018, at Respondent no.1 hospital as a consequence of which she has suffered damage of her intestine measuring 19 cm and has undergone multiple surgeries in the month of February, 2018, and was scheduled for further medical treatment PAC for stoma closure in the month of May, 2018 at Respondent no. 2 Hospital, which she is now being denied or is allegedly postponed for the last two visits for the sole reason that a complaint has been lodged against the hospital authorities for the negligence in providing proper medical treatment.

The Petitioner no. 1 has suffered immense mental trauma and strain to her health due to the gross medical negligence of doctors at Respondent no. 1 Hospital putting her life at high risk. The Respondents have therefore failed in providing quality medical assistance to Petitioner no. 1.

The Petitioner no. 1, on 02.02.2018 went to the Respondent no. 1 Hospital for her routine check-up as she was in her last term of pregnancy, but was admitted to the hospital as she had grown really weak. The doctors had informed her that they will perform cesarean operation on her on 05.02.2018 but due to her weak and deteriorating condition they had to perform the operation on 03.02.2018. The Petitioner no. 1 delivered the baby girl on 03.02.2018. During operation the Petitioner no. 1 experienced excessive blood loss because of which her family members were asked to arrange for blood. Her husband, Petitioner no. 2 therefore arranged for it.

Petitioner no. 1 was conscious throughout the operation. She recalls that even after the delivery, the attending doctors were constantly talking to each other and had left her unattended with her stomach cut open for half an hour, and then later completed the stitching up of her stomach.

Post delivery, Petitioner no. 1 complained of heaviness in the lower abdomen and continuous stomach ache. She was vomiting constantly. The vomit was green in colour and had a disgusting odour. She was also unable to pass stool for 4 days. Petitioner no. 1, and also often at times her mother, would complain to the doctor of the complications experienced by her, but the doctors paid no heed to it and shrugged it off by prescribing her medicines without any diagnosis. Petitioner no. 1 also complained that the doctor would also often accuse her of over-reacting. On 13.02.2018 Petitioner no. 1 was discharged from Respondent no. 1 Hospital, despite the fact that the complications still persisted.

On 14.02.2018, the petitioners 1 and 2 had to again visit to the emergency ward at Respondent no. 1 Hospital, because of the worsening condition of Petitioner no. 1 with unbearable abdominal pain. The doctor instead of admitting her, prescribed her medicines for gastric pains without conducting a proper diagnosis. The petitioner no. 1 repeatedly complained of heaviness in the stomach to the doctors but to no avail. Their entry was not even recorded by the Respondent no. 1 hospital.

The health condition of petitioner was deteriorating. On 15.02.2018, at around 8:30 pm, Petitioner no. 1 complained of heavy abdominal pain and continuous vomiting, and was thus rushed to the emergency ward of Respondent no. 1 hospital, accompanied by Petitioner 2, her mother and her father. Petitioner no. 1 vomited the entire way to the

hospital, and also inside the hospital corridors, where the staff was very rude to her and scolded her for dirtying the corridor floors. There the attending physician gave her injection Rantac/Emset. At around 10:00 pm Petitioner no. 1 was referred to Respondent no. 2 Hospital with suspected subacute intestinal obstruction. No referral service was provided by Respondent no. 1 Hospital, they therefore had to take an e-rickshaw to Respondent no. 2 Hospital.

At around 10:15 pm on 15.02.2018, the doctor in the emergency ward at the Respondent no. 2 Hospital examined Petitioner no. 1 and asked her to get a X-ray and an ultrasound examination. On 16.02.2018, at 2:30 am the X-ray examination was done and at 5:00 am Petitioner no. 1 went for her ultrasound examination, where the doctor had to do the ultrasound examination multiple times to ascertain that there is some foreign substance in her abdomen.

The gynaecologist saw the X-ray and Ultrasound reports and asked the husband, Petitioner no. 2 to arrange blood for an emergency surgery to be carried out on the same day. No information regarding the operation was given, irrespective of the Petitioner no. 1 and her family asking multiple times.

Petitioner no. 1 was asked to get another ultrasound before the operation. Petitioner no. 2 was asked to give written consent for the surgery. The doctor informed that the patient was in a critical condition and any further delay could have been fatal and life threatening.

By 3:30 pm the blood was arranged for, and petitioner no. 1 was taken to the operation theatre. The family was still unaware of the reasons for the operation. At 4:40 pm, Petitioner no. 1 came out of the operation. It was after the operation that the family and petitioner no. 2 were informed of a mop measuring 25x20cm that was removed during the operation from the stomach of Petitioner no. 1.

After operation, Petitioner no. 1 was moved to the ICU. The doctors informed that 'a mop' of dimensions 25x20 cm was inside the body and they tried to save her small intestine by stitching it. Even after the operation, her stomach ache and vomiting continued.

On 20.02.18, Petitioner no.2, husband of Petitioner no. 1 filed an FIR against Respondent no.1 Hospital at Jama Masjid Police Station.

On 21.02.2018, the doctor came in the morning for a regular check-up to examine the wound. After smelling the wound, he called in many doctors and there itself opened the stitches. Later they again took her for another operation. During the operation '19 cm' of the small intestine was removed because it was severely damaged and a passage was made on

the right side of the body for the passage of stool. The Petitioner no. 1 was discharged from the Respondent no. 2 hospital on 06.03.2018.

On 23.04.2018, the doctors at Respondent no. 2 Hospital informed the Petitioner no. 1 would require another surgery for the closure of the passage that was created earlier.

On 02.05.2018, Petitioner no. 1 accompanied by her husband, Petitioner no. 2 visited the hospital to confirm the surgery date and were informed by the doctor that the surgery will be conducted on 07.05.2018.

On 07.05.2018, the doctor at respondent no. 2 hospital did not attend the petitioner and gave a further date without any treatment.

On 10.05.2018, the doctor at respondent no. 2 hospital denied or allegedly postponed further treatment to Petitioner no. 1 saying that since Petitioner no. 2 filed a complaint against all the medical negligences that included both the hospitals, the police are questioning them. The doctor suggested that they should either go to another hospital for the further treatment or should return to this hospital only after one month.

Order

22.02.2019

1. The learned counsel appearing for the petitioner seeks time to respond to the affidavit filed on behalf of respondent no.3. Insofar as her current medical needs are concerned, this Court is informed that the petitioner has been regularly availing the services at respondent no.2 hospital (Lok Nayak Hospital). In this regard, it is clarified that respondent no.2 shall render all necessary medical aid to the petitioner free of cost.
2. List on 05.07.2019.
3. Order *dasti* under signatures of the Court Master.

5. Ramanchal Bhoi Vs. Union of India & 7 Ors. W.P. (C) No. 20996/ 2018

Synopsis

The petitioner in this writ petition seeks to high light the failure of state agencies in proper implementation of necessary provision of National Food security Act, and deficiencies in the implementation of schemes, meant for reduce maternal mortality and infant mortality

funded by the Government of India implemented through Government of Odisha. The issues concern is the systemic failure, which has resulted in denial of benefit to Josada Bhoi, during her pregnancy, under the Janani Suraksha Yojana (JSY), the Mamata Scheme, the National Family Benefit Scheme (NFBS) and the Integrated Child Development Schemes (ICDS) no such support provided to her. While she is legally entitled to get the benefits. Although the interrelatedness of these schemes was recognized by the Supreme Court way back in an order dated 28th November 2001 in Writ petition No. 196 of 2001 (People's Union for Civil Liberties v. Union of India, hereafter the PUCL Case and thereafter periodically orders by way of mandamus have been issued to the Union of India and the individual states, much remain to be done on the ground, as the case of Josada Bhoi reveals, death of Josada Bhoi death fits in to the internationally accepted definition of maternal death in terms of the period of death and the cause of death. The Josada Bhoi died in the District Head Quarter Hospital, Nabarangpur, on 06.08.2018 during her treatment in the aforesaid Hospital.

The petitioner is a citizen of India and cause of action arose within the territorial jurisdiction of this Hon'ble Court.

The fact leading to file this case is that wife of the petitioner was a pregnant woman. This is her second pregnancy. As per guide line her name has been registered under ICDS scheme, accordingly a Mother and Child Tracking System (MCTS) card has been issued in her favour. The petitioner humbly submits that on 06.08.2018 at early morning the wife of the petitioner felt chest pain, therefore, immediately family members tried to contact ambulance service provided by the Central and State Govt., by 102 & 108 Ambulance. After several request 102 & 108 Ambulance did not arrived. Finding no other alternative way the petitioner took her wife to Sinapali Hospital by Bike and admitted their her OPD No. is vide OPD No. 8763 dated 06.08.2018, after preliminary check up the doctor referred her to Community Health Centre, Khariar. There also the duty doctor refer her to District Head Quarter Hospital, Nuapara,. After reaching the District Hospital, immediately I admitted my wife and call the doctor for her check up, the doctor come and declare her dead.

In this case wife of the petitioner was the victim of negligence and insensitively shown by the entire system starting from the Sub- Health Centre, Community Health Centre and District Head Quarter Hospital to the unavailability of Medicinal and specialist's services resulting in his wife's death. The petitioner has filed this petition to ensure implementation of government schemes, to improve the conditions in government aided Hospitals and to obtained justice for Josada Bhoi family in the way of compensation and financial assistance.

The petitioner respectfully submits that wife of the petitioner was check up health regularly. It is pertinent to mentioned here that before some days the petitioner took her wife for check up at Community Health Centre, Sinapali. The doctor stated that everything is fine and prescribe some test.

As per the norms of the National Health Mission a pregnant women has to be provided antenatal services which includes two shots of tetanus injection, four checkups by the ANM, and nutritional support through the ICDS initiative at the village level. In the present case the wife of the petitioner was not covered under MAMATA Scheme which along with antenatal, post natal care and immunization also provides partial wage compensation (Rs. 1,500 in the sixth month of her pregnancy, and 1,500 after the completion of three month of the child), but here in this case even though the wife of petitioner covered under this scheme she had not get any incentive from the govt.

Despite there being a provision under National Health Mission free ambulance services that would facilitate the patients' movement from her home to the health services and then back to her home; but here in this case the petitioner has not get any facility as per the norms is clear violation article 14 & 21 of the constitution of India.

As per Indian Public Health Standard mentioned that every Community Health Centre should have equipped with Blood Bank facilities, Ultra Sonography Diagnostics Test Centre. Due to lake of the diagnostics test centre the wife of the petitioner travelled about 45 km in a risk condition to checkup her pregnancy. If the diagnostics centre, blood bank and doctors are available in the Community Health Centre, Sinapali than precious life of the petitioner wife and baby of the petitioner must be saved.

The government in the Centre has rolled out National Health Mission in all the states of India to attain universal access to equitable, affordable and quality health care services, accountable and responsive to the needs of the poor, with effective inter-sect-oral convergent action to address the wider social determinants of health. That the Government of India has initiated a strategic approach- Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) that embodies its vision for comprehensive and integrated health services, most importantly for adolescents, pregnant and lactating women, mothers and children.

There is a need to recognize neglectful, abusive and disrespectful treatment of Josada Bhoi throughout the course of her pregnancy and also at the health facility. She was not provided adequate care and services when she reached the hospital, during her pregnancy. This demonstrates that mistreatment has occurred at the level of interaction between her

and the service providers as well as through systemic failures at the health facility and health system levels.

The programme created a tiered healthcare delivery system to guarantee, inter- alia, maternal and child health services to all communities and imposed legal obligations on each entity to provide services such as those outlined below.

Sub Health Centre (SHC) of Sub centre:-

Should have at least one auxiliary nurse midwife (ANM), one male health worker (HW), four beds with mattresses, a fully equipped labour room with table, a fully equipped Newborn Care Corner, specific equipment for the sterilization of medical instruments and various supplies and medicines, available.

Early registration of all pregnancies, ideally within the first trimester,

Minimum of four antenatal check-ups: first visit to the antenatal clinic as soon as pregnancy is assumed, second between the fourth and sixth month (at around 26 weeks), and the fourth and ninth month (at around 36 weeks)

Associated general services, such as the measurement of weight and blood pressure:

Provision of supplements including folic acid at the beginning of the first trimester and iron at the beginning of the second trimester;

Vaccines, including an injection for tetanus toxoid;

Treatment of anemia;

Malaria prophylaxis in malaria epidemic zones (such as Odisha);

Counseling and referral for Reproductive Track (RTIs) and Sexually Transmitted Infections (STIs);

Disseminating information about government incentive schemes;

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

A minimum of two postpartum home visits, the first within 48 hours of delivery, the second within 7-10 days post delivery.

Implementation of national health programmes, the Universal Immunization programme and Reproductive and Child Health Programme.

Organization of Village Health and Nutrition Day (VHND)

Primary Healthy Centre (PHC):-

All services available at SHCs;

Should have staff of 13, including MBBS doctor who acts as Medical Officer (MO), a pharmacist, a laboratory technician, 3 ANMs, 2 health assistants, 2 multi-skilled workers and 1 sanitary worker cum watchman. In addition to SHC equipment, a laboratory, additional medicines, and a means of doing laundry should be available.

Implementation of the Janani Surakshya Yojana (JSY) scheme;

24-hours emergency care including institutional delivery services for both normal and assisted deliveries, and

Full coverage of maternal diseases/health conditions

Postnatal care including the initiation of early breastfeeding and two postpartum home visits at a minimum;

Range of family planning including transport either by PHC vehicle or hired vehicle for which funds will be provided by the Government.

Referral services including transport either by PHC vehicle or hired vehicle for which funds will be provided by the Government.

Accountability should be ensured by posting the Charter of Patients' Rights and having an active Rogi Kalyan Samiti (RKS) committee to monitor and seek to improve PHC services.

Community Health Centre's (CHC):-

All services available at PHCs;

Essential and emergency obstetrics, gynecological, pediatric, dental and AYUSH care;

Minimum staff of 46 persons, including 1 Block MO overseeing 5 specialists (general surgeon, physician, OBGYN, pediatrician and anesthetist), 1 dental surgeon, 2 general duty MBBS doctors, 1 AYUSH doctors, 10 staff nurses, 2 pharmacists, 2 laboratory technicians, 1 radiographer, 1 vaccine assistant and many more staff.

Full range of family planning services;

Safe abortion services;

Blood bank facility;

Essential laboratory services; and

Implementation of all National Health Programmes

Janani Surakhsya Yojana (JSY):-

A core component of the NRHM is the JSY Programme described as a:

“Safe motherhood intervention under the (NRHM) will be implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. [JSY] is being implemented in all states and UTs with special focus on low performing states. JSY is a 100% centrally sponsored scheme and it integrated cash assistances with delivery and post delivery care.”

Women in Odisha, which is a Low Performing State (LPS) are entitled to the following entitlements:

JSY BENEFIT FOR INSTITUTIONAL DELIVERIES						
(In Rupees)						
Rural			Urban			
Category of States	Assistance to mother	Assistance to ASHA	Total	Assistance to Mother	Assistance to ASHA	Total
LPA*	1400	600	2000	1000	400	1400

Mamata Scheme (Specific to Odisha):-

Applicable throughout the state in all 318 rural projects, Mamata is a conditional electronic cash transfer maternity benefit scheme aimed at curbing the high rates of maternal and infant mortality by promoting positive child and maternal health and nutrition practices.

The Mamata scheme offers pregnant and lactating women aged 19 years and more financial incentives to complete their trimesters of pregnancy with adequate antenatal care.

Because Mamata payments are delivered by e-transfer, women are required to open bank accounts into which the funds can be deposited. Administratively, Anganwadi Workers (AWWs) are responsible for the submission of names of beneficiaries to their supervisors for the payments to be made.

Janani Shishu Surakhsya Karyakram (JSSK):-

Though NRHM, the Government launched the JSSK scheme in June 2011 as a means of elimination out-of pockets expenses incurred by pregnant women and for sick newborns, many of whom die on account of poor access to health facilities. The scheme permits pregnant women who seek institutional delivery and sick newborns to enjoy the benefits of absolutely free care in all government health facilities until 30 days after birth.

These health services are available to all women who deliver in government health facilities, regardless of age, economic status, or the number of children they have. The services include delivery, medicines, consumables, essential diagnostics, blood transfusions, nutritious meals (up to 3 days for normal delivery patients, and 7 days for Caesarean section patients), free transportation to and from the facility, and the exemption from all user charges.

The petitioner submits that, wife of the petitioner being a poor woman, ANC services have not been provided to nor has she received the essential pre-natal entitlements under the National Maternity benefit Scheme (NMBS) or services and post – delivery cash incentives under the JSY for institutional deliveries and the JSSK.

Article 21 of the Constitution of India guarantees the right to life and personal liberty. The Hon'ble Supreme Court has interpreted Article 21 to include numerous fundamental rights already protected under international law, including a fundamental right to health (both physical and mental), the right to live with dignity and the right to be free from torture and cruel, inhuman, or degrading treatment. Article 14, 15 and 38 of the Constitution of India.

The petitioner submitted a representation before the Opposite Parties ventilating her grievances and non implementation of the schemes in its proper manner and prayed for compensation from the state but the state authorities are sitting silent over the representation and did not take any action.

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 Article 32 by this Court or by the High Court under Article 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 of its contravention. A claim in public law

for compensation for contravention of human rights and fundamental freedoms, the protection of which is guaranteed 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 the purported exercise of their powers, and enforcement of the fundamental right is claimed by resort to the remedy in public law under the Constitution by recourse to Articles 32 and 226 of the Constitution.

The purpose of public law is not only to civilize public power but also to assure the citizens that they live under a legal system which aims to protect their interests and preserve their rights. Therefore, when the court moulds the relief by granting compensation in proceedings under Article 32 or 226 of the Constitution seeking enforcement or protection of fundamental rights, it does so under the public law by way of penalizing the wrongdoer and fixing the liability for the public wrong on the State which has failed in its public duty to protect the fundamental rights of the citizen.”

1. However, the action of the opposite parties in not finalizing the matter in spite of repeated approach amounts to callousness and irresponsibility of the Opposite parties for which the petitioner has been seriously prejudiced.
2. The petitioner therefore, finding no other speedy , efficacious and alternative remedy craves indulgence of the extra ordinary jurisdiction of this Hon’ble Court to interfere in the matter of greater interest of justice.

Prayer

Under the facts and circumstances it is therefore humble prayed that the Hon’ble Court may graciously be pleased to admit the writ application, issue notice to the opposite parties to show cause as to why the reliefs prayed for shall not be granted in favour of the petitioner and if the opposite parties failed to show cause or showed insufficient cause, the Hon’ble court may further be pleased to issue direction to the opposite parties,

- i. To pass an order to set up an independent enquiry committee to review the medical negligence, which resulted in the death of the petitioner wife.
- ii. To pass an order to reimburse petitioner for any expenditure incurred and provide a compensation of Rs. 1 lakh for mental and physical trauma and loss of her wife.

- iii. To pass an order to ensure effective implementation of the guarantees in Janani Suraksha Yojana(JSY), Janani Sishu Surkhay Karyakrm (JSSK), Mamata Scheme and other benefits.

And may further pleased to pass such other order/orders, direction/directions may be deem fit and proper in the interest of justice.

And for this act of kindness, the petitioner as in duty bound shall ever pray.

Order

30.04. 2019

The petitioner is stated to have filled a representation vide Annexure- 5 before the Collector-cum- Chairman, Zilla Swasthya Samiti, Nuapara- Opposite party No. 6 for redressal of her grievance. The said representation is stated to be still pending.

Taking into consideration the facts and submissions and without going into the merit of the case, the writ application is disposed of, directing the Collector- cum- chairman, Zilla Swasthya Samiti, Nuapara- Opposite Party No- 6, to dispose of the representation of the petitioner vide Annexure- 5 in within a period of two months from the date of receipt of a certified copy of this order.

The petitioner is directed to supply a copy of the writ application containing all the Annexures along with a certified copy of this order to the Opposite Party No. 6 for convenience and reference to Annexure- 5.

The writ application is accordingly disposed of.

Denial of Medical Services and Discrimination to Plhiv

1. Rekha Devi vs. Union of India through the Ministry of Health and Family Welfare & Others, DN: 512914/2015

Synopsis

People Living with HIV/AIDS (PLHIVs) in New Delhi cannot access adequate treatment. Recent slashes to the health budget have made it more difficult for PLHIV to access services, government entitlement programs, and medicines. HIV+ pregnant women in Delhi face discrimination throughout their pregnancies.

Facts

The PIL includes cases of routine verbal abuse, illegal fees, and neglect during antenatal care checkups and deliveries. The PIL prays for increased doctors to treat PLHIV, free medication, greater medication stocks in anticipation of budget-related shortages, adequate stocks of HIV+ positive delivery kits, and to increased access to treatment for opportunistic infections.

Orders

25.05.2017

1. This writ petition has been filed complaining that the Anti Retroviral Treatment for

the people living with HIV is not adequately available in Delhi. The respondents have filed an affidavit explaining the circumstances in which the shortage had resulted on some occasions and also indicated the steps which have been taken to remove the same. We are assured that every steps shall be taken to ensure that no such shortage occur in future. In view thereof, the prayer made at Sl. Nos. (iii) to (viii) stands

2. In prayer no.(i). The petitioner seeks direction to the respondent nos.1 to 4 to ensure that all the vacant post of doctors and other staff at the Anti Retroviral Treatment Centres (ART Centres) in Delhi are filled up. There can be no dispute to the fact that these posts are required to be filled up at the earliest. The respondents shall ensure that all vacant seat to the posts of doctors as well as ancillary staff in ART Centres in Delhi are filled up at the earliest.

3. A grievance is also made by the petitioner that to avail the medical facilities, for a person below the poverty line, who is HIV positive, the ART Centres are insisting of production of Aadhar Card, even though the person produces a BPL or AAY card.

4. We are informed by Mr. Sanjay Jain, learned ASG that as per the short affidavit filed by the Respondent no.4/GNCTD, the Aadhar card cannot be insisted upon and that production of any identity proof in the nature of ration card/voter card/ART treatment card can be produced for availing medical facilities. The applicant can also submit the National Food Security Card as income proof, as these cards are intended for the population living below the poverty line.

5. The respondents shall ensure that the staffs at the ART Centres are informed about all these requirements and options and that no person is denied the medical facility despite production of the identification.

6. Ld. Counsel for the petitioner submits that in view of the above directions, all prayers made in the writ petition are satisfied. Accordingly, the writ petition and application are disposed of in the above terms.

2. Mr. Hxxx Vs. Lok Nayak Jai Prakash Narayan Hospital & Ors. W.P. (C) 9563/2017

Synopsis

The Petitioner who is a Person Living with HIV (PLHIV) and has been treated unfairly and denied the right to healthcare services. The Petitioner had met with an accident following which he had availed medical treatment from Babu Jagjeevan Ram Memorial Hospital and was referred to Lok Nayak Jai Prakash Narayan Hospital both of whom have refused

surgeries due to which there is a chance of infection and gangrene on his injuries, any delay in treatment of which, may result in amputation of his left leg.

Facts

On 09.08.2017 the Petitioner had met with an accident following which he had availed medical treatment from two govt. hospitals both of whom have refused surgeries due to which there is a chance of infection and gangrene on his injuries. He was denied the right to treatment at two Government hospitals namely Babu Jagjeewan Ram Memorial Hospital and Lok Nayak Jai Prakash Narayan Hospital after meeting with an accident that left his arm and leg severely injured.

The prolonged delay risked him getting infected with gangrene and possibly leading to amputation of his leg. Given the dire circumstances, he approached and received treatment from a Private hospital costing him 1.5 lakhs. A writ petition has been filed in the honourable High Court of Delhi seeking compensation of the amount spent by him due to the discrimination faced which comes under the aegis of his fundamental right to equality and right to life under Article 14 and 21 of the Constitution of India as well as under Section 3 of the HIV & AIDS Act, 2017.

Orders

30.05.2018

File received through office noting for direction. Hon'ble Division Bench vide order dated 23.05.2018, gave direction for release of documents which are kept under sealed cover to the petitioner's counsel.

The documents which are kept in sealed cover are returned to the petitioner's counsel in the Court. Statement of learned counsel for the petitioner recorded in this regard.

No further order required.

3. Sanjeet Singh Vs. The Union of India & 7 Ors. CWJ No. 2001/ 2018

Synopsis

For that the right to health is a fundamental right as enshrined in Article 21 of the Constitution.

- For that despite repeated representations and requests there is serious inaction on behalf of the respondents.
- For that without proper CD-4 count it is highly improper to medicate a *Person Living with HIV+/AIDS* (Hereinafter, referred as PLHA).
- For that a fault in the CD-4 count of a pregnant PLHA woman may lead to spread of the HIV form her to her child.
- For that CD-4 count of every PLHA on ART is mandatorily taken on regular intervals.
- For that CD-4 count is instrumental in determining the line of treatment of a PLHA.
- For that the inaction on behalf of the Authorities is arbitrary and violative of Article – 14 and 21 of the Constitution of India.

For that writ jurisdiction is available efficacious remedy as the violation of fundamental rights of the petitioner, which can be redressed only under the equitable and extra-ordinary writ jurisdiction of this Hon'ble Court under Article 226 of the constitution of India.

That the Petitioner is himself a PLHA and a prominent social activist in the State working for the cause and rights of PLHA and eliminating the stigma existing in the society with respect to PLHA and the disease. Further, the Petitioner has no personal interest direct or indirect in the subject matter of the PIL.

That the Petitioners above named have not moved earlier before this Hon'ble Court praying for the same relief and the Petitioner is a Citizen of India.

The Petitioner submits that only the facts, which are relevant for adjudication of the present case, are being stated in the present Writ Petition.

The CD-4 machine is a vital component and instrumental in ascertaining the level of HIV+ infection of a PLHA. Depending upon the report of CD-4 count the line of treatment of the PLHA is decided and the drugs are given accordingly. Further, CD-4 count of every PLHA on ART is mandatorily taken once in every six months. Moreover, if proper drug is not given or in absence of proper line of treatment to PLHA, there is every possibility that the PLHA's body will develop resistance against the line of treatment or drug and the HIV+ status of such PLHA may consequently lead to AIDS. The CD4 machine at the Chapra ART Center is not functioning for more than last three months.

The CD-4 machine is instrumental in the base line tests and treatment of a PLHA men or women. Prevention of transmission of HIV+ from a pregnant mother to her child in womb

and its treatment is also dependent upon the CD-4 count of that PLHA pregnant woman. In absence of the same the HIV virus can easily spread from mother to child. Inadequate and inaccessible maternity facilities violate a PLHA woman's right to life, equality and dignity guaranteed under Articles 21, 14 and 15 of the Constitution.

It is humbly submitted that at the said ART Center despite the mandatory guidelines only distributes ART medicines only for two hours i.e. from 11:00 AM – 1:00 PM. Further, the caretaker & in-charge of the said ART act in hand in gloves in order to charge money for free Baseline tests from the PLHA. Further, the PLHA have been compelled to buy a note-book for Rs. 10/- in order to avail their ART medicines. It is pertinent to mention here that as per NACO guidelines the Baseline tests have to be conducted free of cost at the ART Center. Further, the profiles of the Patient & the record of medicines & his condition have to be maintained in a *green-book* systematically.

It is humbly submitted that under government schemes, pregnant women receive an incentive payment for choosing to deliver in an institution. It is fundamentally unjust to encourage HIV+ infected women for such inefficient institutional deliveries wherein advanced CD4 machine & the said ART center providing is not functional from last three months. Inadequate and inaccessible maternity facilities violate a woman's right to life, equality, dignity, and equality guaranteed under Articles 21 and 15 of the Constitution.

The Petitioner has been continuously raising the issue with the Authorities but till date the reason best known the CD-4 machine has not been made functional. The Petitioner has filed representations dated 12.12.2017 with the authorities.

It would not be out of place to mention that in *CWJC No. 9699 of 2017 : Sanjeet Singh Vs. Union Of India & Ors.* related to appointment of a Doctor & Nurse at the said Chapra ART Center. The Hon'ble Court vide its Order dated 02.12.2015 stated:-

“Considering the matter in its entirety and in the interest of justice, we close this PIL with a direction to the respondent No.7, namely, the Project Director, Bihar State AIDS Control Society, Patna, to ensure that the doctor and the nurse, who have been posted at A. R. T. Centre, Sadar Hospital, Chapra, shall perform their duties as per requirements by the National AIDS Control Organization, till 05.00 PM.”

The reason best known to the Respondent Authorities the matter remains stand-still and no action has been taken.. Consequently, the condition of PLHA and their treatment is getting worsen and the said inaction of the Authorities is also indirectly adding fuel to the fire of spread of the disease.

The Petitioner is left with no alternative and efficacious remedy than to move before this Hon'ble Court.

The Petitioner has not moved earlier before this Hon'ble Court for the relief prayed for in the present Petition.

It is therefore, prayed that your Lordships may graciously be pleased to admit the Writ Petition and issue notice to show cause upon the Respondents as to why the prayer made in Paragraph No.1 of the Writ Application be not allowed and on return of the same your Lordships may be pleased to make the rule absolute.

A N D / O R

Pass such other order or orders, as your Lordships may deem fit and proper in the facts and circumstances of the present case. And for this, the Petitioner shall ever pray.

Order

07/ 05/ 2019

Heard Mr. Vikash Kumar Pankaj, learned counsel for the petitioner. While Mr. Ajay Bihari Sinha represents the respondents no. 2, 3, 4, 5 and 7, the Project Director, Bihar State AIDS Control Society, Patna is represented through Mr. K.K.Sinha and the Union of India in its Ministry of Health is represented by Ms. Punam Kumari Singh, learned Central Govt. Counsel. An issue of grave Public Interest is raised in this writ petition but unfortunately it is made limited to the facility available for the HIV+ infected patient at Sadar Hospital, Chapra.

A counter affidavit is filed by respondent no.5 i.e. Chief Medical Officer on behalf of the Department as well informing that the only available CD4 machine and the Anti Retroviral Therapy Center within the Sadar Hospital, Chapra is functional and regular Pathological tests are being carried out of all such patients. Mr. Pankaj, learned counsel appearing for the petitioner, while confirming to the affidavit submits that the steps for providing regular medical treatment to HIV+ infected patients no doubt has improved but the affected patients do apprehend a laxity and thus pray for a direction to be given to the concerned authority including the Department of Health as well as Bihar State AIDS Control Society to maintain the same standard of medical facility all through the year as well as to maintain regular supply of medicines to such patients in the other centers running across the State as well. We are in absolute agreement with the concern shown by the petitioner in the

maintenance of facility/ medicines on regular basis to the patients, all through the year and there cannot be any contest to what the petitioner raises nor this litigation can be called adversarial. Having observed as such, that the cause raised by the petitioner has been addressed to and medical facility having improved at the Anti Retroviral Therapy (ART) Center at Saran at Chapra, we would expect the concerned authorities i.e. National AIDS Control Organization, New Delhi, the Bihar State AIDS Control Society, Patna as well as the Ministry of Health, Govt. of India, New Delhi to ensure that the medical facilities to HIV+ patients across the State, at all the ART centres are maintained and the centers are functional with CD4 machine as well as medical facilities as required to cater to such patients, are available all through the year. With the advice above, we dispose of the writ petition.

4. Shebani Rose Verma Vs. Ministry of Health & Family Welfare & Anr. W.P. (C) 8475/ 2018

Synopsis

This writ petition is being filed under Article 226 of the Constitution of India seeking the aid of this Hon'ble Court to issue appropriate orders to the Respondents to notify the HIV and AIDS (Prevention and Control) Act, 2017 so that the people affected by HIV can effectively exercise their right under the statute.

The petition is being filed as a safeguard for the rights of those people who have been living with HIV and AIDS (hereinafter referred to as PLHIV). Due to the delay in notification of the HIV and AIDS Act 2017, the rights guaranteed to the PLHIV under the statute are being curtailed.

As of 2016, there are 2.1 million people in India living with HIV. Due to its large population size, India has the third largest HIV epidemic in the world. India's epidemic is concentrated among key affected populations including sex workers and men who have sex with other men.

The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 of the Parliament obtained the assent of the President on 20th April, 2017 and was published by the authority in the Official Gazette of India on 21st April, 2017.

Salient features of the HIV and AIDS (Prevention and Control) Act, 2017:

- The term protected person under the Act includes persons who are HIV positive or persons who ordinarily reside/resided with a person who is HIV positive

- Prohibits discrimination against people with HIV in accessing healthcare, acquiring jobs, renting houses, or in education institutions in public and private sectors.
- Prohibits unfair treatment of people living with and affected by HIV with regard to accessing public facilities.
- Punishes any individual from publishing information or advocating feelings of hatred against HIV+ persons and those living with them with imprisonment for a term which shall not be less than three months but which may extend to two years and with fine which may extend to one lakh rupees, or with both.
- Disclosure of HIV status cannot be done without informed consent, if required an order of the Court.
- Punishes any individual who discloses information regarding HIV status of a protected person which is obtained by him in the course of, or in relation to, any proceeding before any court, with fine which may extend to one lakh rupees unless such disclosure is pursuant to any order or direction of a court.
- Establishment of Ombudsman to inquire into the violations of the provisions of the Act, upon a complaint made by any person. The Ombudsman also shall maintain records in a prescribed manner. The Ombudsman on receipt of a complaint shall hear the parties and pass orders as he deems fit within thirty days of the receipt of the complaint.
- Establishments maintaining records of information of PLHIV have been asked to adopt data protection measures as the Act requires that “no person shall be compelled to disclose his HIV status except with his informed consent, and if required by Court order”
- Central and State Governments take measures for providing ART and management of opportunistic infections. They should also take measures to prevent the spread of HIV/AIDS through creation of welfare schemes.
- A PLHIV under 18 years has the right to reside in a shared household.
- Mandates authorities to provide a safe working environment to healthcare workers
- Cases relating to HIV+ persons shall be disposed off by the Court on a priority basis.

The protection offered in this Act extends to healthcare providers exposed to PHIV in the form of certain standards and guidelines to be followed where there is a significant risk of occupational exposure to HIV.

The Central and State Governments are to take measures to prevent the spread of HIV and AIDS, facilitate their access to welfare schemes, and take measures for provision of anti-retroviral therapy and management of opportunistic infections.

However, till date the said Act has not been notified and put into force by Respondent No.1. Due to its lack of implementation, the rights of PHIV are being violated.

The non-compliance to the Act of 2017 puts the health and life of those suffering with HIV or AIDS throughout the country under great risk. India being the home to the 3rd largest population of PHIV, it is essential that the abovementioned law is enforced diligently.

Facts

Facts leading to this Writ Petition:

- As per the fact sheet of the World Health Organization N 360; updated on July 2015. “In 2014, 1.2 [1.0-1.5] million people died from HIV-related causes globally. There were approximately 36.9 [34.3-41.4] million people living with with HIV at the end of 2014 with 2.0 [1.9-2.2] million people becoming newly infected with HIV in 2014 globally. “
- India has the third highest number of estimated people living with HIV in the world. According to the HIV Estimations 2012, “the estimated number of people living with HIV/AIDS in India was 20. 89 lakh, with an estimated adult (15-49 age group) HIV prevalence of 0.27% in 2011.
- On April 20, 2017 the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (Prevention and Control) Bill, 2017 was given assent by the President of India and was subsequently published in the Official Gazette on April 21, 2017. However till date, the said Act is still not been enforced due to the lack of a notification by the Respondent No. 1 and hence there is a failure of its implementation. This is resulting in a major hurdle and that of the increased pendency of cases involving people with HIV and AIDS, and their rights.

Salient features of the HIV and AIDS (Prevention and Control) Act, 2017:

- The term protected person under the Act includes persons who are HIV positive or persons who ordinarily reside/resided with a person who is HIV positive

- Prohibits discrimination against people with HIV in accessing healthcare, acquiring jobs, renting houses, or in education institutions in public and private sectors.
- Prohibits unfair treatment of people living with and affected by HIV with regard to accessing public facilities.
- Punishes any individual from publishing information or advocating feelings of hatred against HIV+ persons and those living with them with imprisonment for a term which shall not be less than three months but which may extend to two years and with fine which may extend to one lakh rupees, or with both.
- Disclosure of HIV status cannot be done without informed consent, if required an order of the Court.
- Punishes any individual who discloses information regarding HIV status of a protected person which is obtained by him in the course of, or in relation to, any proceeding before any court, with fine which may extend to one lakh rupees unless such disclosure is pursuant to any order or direction of a court.
- Establishment of Ombudsman to inquire into the violations of the provisions of the Act, upon a complaint made by any person. The Ombudsman also shall maintain records in a prescribed manner. The Ombudsman on receipt of a complaint shall hear the parties and pass orders as he deems fit within thirty days of the receipt of the complaint.
- Establishments maintaining records of information of PLHIV have been asked to adopt data protection measures as the Act requires that “no person shall be compelled to disclose his HIV status except with his informed consent, and if required by Court order”
- Central and State Governments take measures for providing ART and management of opportunistic infections. They should also take measures to prevent the spread of HIV/AIDS through creation of welfare schemes.
- A PLHIV under 18 years has the right to reside in a shared household.
- Mandates authorities to provide a safe working environment to healthcare workers
- Cases relating to HIV+ persons shall be disposed off by the Court on a priority basis.
- The act also emphasizes the fundamental right to provision of health care services for all the PLHIV. It mandates for the government to establish welfare schemes and

spread awareness. It also enumerates that health care services cannot be denied to PLHIV.

A significant aspect of the Act is that it does not only cover PLHIV but also considers the people who are in close contact with the PLHIV, such as parents, children, spouse who are in direct contact and also includes healthcare workers.

Even though the Act does not enumerate all the rights available to the PLHIV, it enumerates certain basic rights which are required to guarantee them better standard of living.

As prescribed under the act, no form of discrimination should take place against PLHIV as that of other people.

Right to health is enshrined under Article 21 of the Constitution of India, 1950 and it is the obligation of a State to ensure the creation and sustenance of conditions congenial to good health. Also, Article 14 of the Constitution of India, 1951 guarantees the principle of equality and protects person from discrimination.

Due to the non-recognition of the Act of 2017, it has led to several infringements of the basic fundamental rights of the PLHIV.

Order

The case is on-going.

5. Access to Right & Knowledge (ARK) Foundation & 3 Ors. Vs. The State of N/L & 6 Ors. PIL No. 4 (K)/ 2018

Synopsis

Viral hepatitis caused by these two high-burden viruses- Hepatitis B (hereinafter HBV) and Hepatitis C (hereinafter HCV) -is a major public health challenge that requires an urgent response. Globally it is estimated to have caused 1.34 million deaths in 2015, a number comparable to annual deaths caused by tuberculosis and higher than those caused by HIV. While mortality from HIV, tuberculosis, and malaria is now declining, mortality caused by viral hepatitis which includes HCV is on the rise.

HCV impacts the liver and can lead to acute and chronic liver disease. The virus can cause both acute and chronic infection ranging in severity from mild illness lasting few weeks to a

serious lifelong chronic infection unless diagnosed and cured in time. A significant number of those who are chronically infected will develop cirrhosis of the liver or liver cancer. HCV is transmitted through infected blood. The common modes of transmission are:

- Unsafe injection practices,
- Inadequate sterilization of medical equipment especially syringes and needles in healthcare settings,
- Transfusion of unscreened blood and blood products
- Even though HCV can be transmitted sexually and can be passed from an infected mother to her baby but these modes of transmission are much less common

That 15-45% of infected person recovers within six months without any treatment and the remaining 55-85% of persons develops chronic HCV infection putting them at risk of liver disease, cirrhosis and liver cancer. That the symptoms of Hepatitis C often do not become apparent, sometimes for years until advanced liver disease sets in, which is why it is sometimes called the “silent killer”. Diagnosis and treatment of Hepatitis C before advanced liver damage has developed is key to addressing this major public health challenge and the only way to do that is to make routine screening for anti-HCV antibodies accessible and available in the public healthcare system. If HCV infection occurs in conjunction with HBV infection, sudden hepatic failure can also occur which is why testing and treatment facilities for both HCV and HBV ought to be made accessible to vulnerable populations by the state.

Following initial infection majority of people do not exhibit any symptoms and few people are diagnosed during the initial i.e. acute phase. A large proportion of infected persons develop chronic Hepatitis C, the more serious form of the infection, which may be asymptomatic for many years. During this period, the immune system tries to protect the liver by walling off infected cells; over time this causes scarring which can result in liver cirrhosis, liver cancer, or liver failure later in that person’s life. Therefore, early screening, confirmation of chronic disease and cure for HCV infection is of vital importance.

Availability of new oral medicines known as directly-acting antivirals (hereinafter DAAs) with high efficacy has changed the treatment landscape of HCV infection. DAAs can cure more than 90% of HCV patients after a short period – usually 12 to 24 weeks of treatment. The high price of DAAs has restricted their use in several countries. However, in India, due to domestic production and generic competition in these medicines—DAAs are available at an affordable price to the government making it cost effective for the public health system

to test and treat HCV. Compared with no treatment, the use of generic DAAs in Indian HCV patients would increase the life expectancy by 8.02 years, increase quality-adjusted life-year (QALYs) by 3.89, avert 19.07 disability-adjusted life year (DALYs), and reduce the lifetime healthcare costs by \$1,309 per-person treated. Treating just 10,000 HCV-infected persons could prevent 3400–3850 decompensated cirrhosis, 1800–2500 of Hepatocellular Carcinoma (HCC), and 4000–4550 liver related deaths.

Due to the overlap between modes of transmission of HCV and HIV; PLHIVs are at a higher risk of HCV infection, as well. This is known as ‘co-infection prevalence’. According to the WHO 2.3 million persons who are HIV+ are co-infected with HCV globally (there are estimated to be approximately 37 million HIV+ persons in the world and 71 million people with chronic HCV infection). On average, it is six times more likely that an HIV-infected person will be infected with HCV than an HIV-uninfected person.

With proper testing and treatment, Hepatitis C can be considered as cured if there is a ‘sustained virological response’ (when the virus becomes undetectable during treatment and remains undetectable for 3 months, after treatment is completed).

Screening and confirmation of HCV infection is a multi-step process: first, testing for anti-HCV antibodies with a serological test identifies people who have been infected with the virus. Subsequent confirmation of HCV chronic infection with HCV ribonucleic acid (RNA) viral load, and finally assessing the stage of a person’s liver disease.

HCV demography in India and Nagaland State:

As per the fact sheet on Hepatitis-C published by the South East Asian Region wing of World Health Organisation (WHO), it has been estimated that there are between three to six million people infected with HCV in India which forms 1% prevalence and also about other critical facts on HCV.

The north and the north-eastern parts of country are particularly affected with HCV posing graver threat to the people particularly living in these regions. (See ANNEXURE-A6) That the northern parts of the country having high prevalence, Punjab in specific, has come out with a standard operating procedures under the Mukh Mantri Punjab Hepatitis-C Relief Fund (MMPHCRF).

According to the World Health Organisation’s most recent estimates, approximately 71 million people worldwide are infected with Hepatitis C (almost twice the number of people living with HIV in 2016. Global modelling suggests that in 2015, there were 1.75 million

new Hepatitis C infections worldwide. Moreover, about 399,000 people each year die from the disease, mostly from cirrhosis or liver cancer, both of which commonly result from chronic Hepatitis C infection. Antiviral medicines, however, can cure more than 95% of those infected.

HIV/AIDS and Hepatitis C are transmitted in essentially exactly the same ways and individuals can often become infected with both diseases. The World Health Organisation has found that, of the 36.7 million people living with HIV worldwide, about 2.3 million of these have either had Hepatitis C or are currently infected with Hepatitis C. Moreover, liver diseases represent a major cause of morbidity and mortality among persons with HIV; co-infected persons are at higher risk of death, and decline at a faster pace.

Hepatitis C is not well documented in India, but according to the most recent estimates, 6-12 million people in India are infected, with about 35,000 deaths each year. The Institute of Liver and Biliary Science (ILBS) noted in 2014 that chronic Hepatitis C infection accounts for 12-32% of liver cancer and 10-20% of cirrhosis cases in India. Most people with the disease are unaware that they are infected, and are therefore at serious risk of developing the more severe, and life-threatening, symptoms.

A 2015 study based on population samples from 15 cities in India showed prevalence of HIV/Hepatitis C co-infection ranging from 2.0% in Dimapur to 28.5% in Kanpur. Furthermore, in another study 16 reported overall 10% HCV seroprevalence among 426 Female Sex Workers (FSWs) in Nagaland. However, HCV sero-reactivity in FSWs who reported injecting drugs was much higher at 46%. In contrast, only 3% FSW participants were found to be HCV sero-reactive in the study conducted in Mumbai

Co-infection is also particularly severe in the Northeast – a 2016 study found a Hepatitis C prevalence of 93% among HIV-positive IDUs, and 34.4% among HIV-negative IDUs.

While the North-east has had particularly poor documentation of Hepatitis C seroprevalence, and Hepatitis C always being an area of concern for the people of Nagaland, it was only in 2005-2006, that the Study Conducted by the Regional Medical Research Centre, NE Region (ICMR) Lab Reports did a small scale study on the disease burden among the Injecting Drugs Users (IDUs) in Kohima and as per the data 30 IDUs have been tested Antibody reactive for HCV out of a total sample size of 98 IDUs.

Another two rounds of studies was conducted in the year 2006 and 2009 by the Indian Council of Medical Research and Kripa Foundation based on the Integrated Bio Behavioural

Assessment (IBBA) in the State of Nagaland and found a Hepatitis C prevalence of 5.4% in round 1 (2006) and 8.7% in round 2 (2009) in Phek, and 16.7% in round 1 (2006) and 20.8% in round 2 (2009) in Wokha among IDUs, respectively. This study conducted in the two subsequent year shows a rapid increase in the rate of infection in the two districts at an alarming rate which only continues to increase.

According to the Nagaland Hospital Authority, Kohima's most recent seven-year report, HCV prevalence in the general population is at 1.8%, which means that it is not only IDUs or other communities who are affected from the virus but also the general mass and the population, which has become a grave issue of public health concern. As a result, public health authorities must focus on the disease as it affects the population as a whole and not just a particular group or communities.

Another study conducted by NHAK in joint partnership with MSD (Merck Sharp and Dohme) Pharmaceuticals Pvt. Ltd in the year 2012-2013 during a ten month (September 2012 to June 2013) reported of 728 tested from the general OPD patients, where 50 patients were tested antibody reactive projecting a percentage of 6.8%, signifying a high rate of infection among the general population posing a grave threat to public health.

The petitioners states that it is particularly the case that mostly people from the poor economic background are affected vastly by this deadly Viral time bomb and for such class of people to get the testing, diagnosis and treatment facilities becomes a burden. That testing and diagnostics process alone for HCV is both costly and time-intensive, and consequently prohibitive to victims unless they receive some form of financial assistance, deterring the infected from seeking any diagnosis.

The petitioners further states that the awareness among the general population is extremely low in the state of Nagaland. According to testimony during HepCoN's awareness programs, the notion on transmission through sweat or sharing of clothing is still prevalent, and most people have misconceptions about the disease. The vast majority of people the foundation has interacted with know nothing about the treatment options available and some doctors in the hospitals are also misinformed on the issue.

In one case, a victim of Hepatitis-C was told by the medical staff that the disease was incurable, and that he had only two years to live. As a result of which, he relapsed into his previous habit of injecting drugs. Overall the lack of information among both the population and the medical personnel has produced lags in diagnosis of several years. One instant of such case, a man diagnosed with HIV in 2000 was only diagnosed with Hepatitis

7 years later, although he had stopped all injecting behaviour, prolonging the treatment for Hepatitis-C.

Diagnosis and Treatment

The WHO guidelines clearly recommend that ‘all adults and children with chronic HCV infection, including people who inject drugs, should be assessed for antiviral treatment’. Several “early adopter” states are showing that rapid scale up of HCV testing and treatment can be achieved through public healthcare system/hospitals, and a reduction in the procurement prices of essential medicines and diagnostics to expand treatment services. Northern states like Punjab and Haryana, in line with the above WHO guidelines have publicly funded HCV testing and treatment programmes, which is a model that the State of Nagaland ought to pay heed of, if not emulate. A sustained public health programme is critical to ensure that people in Nagaland who are silently living with HCV have access to screening for HCV infection and treatment (essential diagnostics and drugs) to prevent/mitigate chronic Hepatitis C can take place, well in advance of irreparable liver damage. These people are at risk of a slow progression to severe liver disease and death, unless they receive timely testing and treatment facility.

The petitioner states that there are two tests which are conducted for HCV diagnosis-HCV screening, followed by HCV viral load testing.

HCV screening is a serological test that identifies development of antibodies in the person’s body which is an immune response to HCV. This antibody test only indicates whether the individual has ever been exposed to the hepatitis C virus. It does not exactly confirm whether the person has HCV infection currently.

Then it is followed by a confirmation test for HCV, viral load testing which is also known as the qualitative test (the Polymerase Chain Reaction Test, PCR) which examines the presence of virus in the blood; positive result test of which confirms the infection in a person, which is needed to confirm chronic infection because in 15-45% of the cases people infected with HCV spontaneously clear the infection by a strong immune response.

Additionally, the degree of damage done to the liver can be assessed by non-invasive tests such as APRI and Fibroscan. Screening and diagnosis of chronic HCV infection is the gateway for treatment services. Early identification of persons with chronic HCV infection enables them to receive the necessary treatment to prevent or reverse progression of liver disease. Testing also provides an opportunity to link to interventions to reduce transmission,

through counselling on risk behaviours and provision of prevention commodities (such as sterile needles and syringes).

HCV is treated with Directly Acting Antivirals (DAAs) i.e. Sofosbuvir in combination with Ledipasvir/ Daclatasvir and Sofosbuvir in combination Velpatasvir which are considered pan-genotypic (cure across all genotypes) and has achieved cure rates above 95%. These medicines are much more effective, safer and better-tolerated than the older therapies. Therapy with DAAs can cure most persons with HCV infection and treatment is shorter (usually 12 weeks). (See ANNEXURE-A3). Another drug called Ribavirin may be added for cirrhotic patients with advanced liver disease (See ANNEXURE-A8) and treatment experienced cases. These medicines are part of the European Association for the Study of the Liver (EASL) recommendations on treatment of Hepatitis C.

These medicines are also a part of the WHO Essential Medicines List updated on March 2017. That despite the medicines for treatment of HCV listed under essential medicine list. That the petitioner also states that other States across the country has managed to list it under the essential medicine list, however, the State of Nagaland has failed to list any of these medicines under its essential drug list making access to these lifesaving combination regimens an impossibility in the public health sector due to their non availability in the government run hospitals in the state of Nagaland.

HCV Diagnosis and Treatment Status in Nagaland

The petitioner states herein that the hospitals in the state of Nagaland, especially the government run hospitals do not have necessary resources and staffs to conduct HCV testing, treatment and the facilities and the cost for both the diagnosis and treatment is prohibitively high in Nagaland. It is also stated herein that the treatment of HCV should happen at the Anti-Retroviral Treatment (ART) Centre, however, despite the presence of 10 ART Centers in the State of Nagaland (District centers) none of them have testing and treatment facilities for HCV.

The diagnostic and screening test can now cost about INR2000-2500 which discourages people, who are likely infected from HCV, from getting the test done, this effects mostly the people coming from poor economic background due to financial barrier, which could also likely contribute to the under-reporting of HCV status in the state of Nagaland.

After the screening test, the confirmation test of Viral Load Testing alone ranges from INR7000-INR9000, and thereafter followed by genotyping test, the facility and provision

of which is not available in the state of Nagaland nor is being done in any of the government run hospital, and hence is being done outside from the state. That the cost of screening, confirmation with HCV RNA viral load and treatment with direct acting antivirals is high in the private sector, especially so for the affected population which may belong to economically weaker sections of society

The cost of treatment is prohibitively high especially for those individuals most at risk of Hepatitis C and who are from vulnerable group, which cost up to INR60000 though the cost are substantially lower than earlier of INR of 4-5 lakhs, most individual are not in a position to cover for full diagnosis and treatment precluding them from getting timely treatment in any of the government run hospital across the state of Nagaland for people infected with HCV. Moreover because a large proportion of the population infected with Hepatitis C is comprised of IDUs, people who have received blood transfusion, sex workers, PLHIV, and others whose families are often either not in a position or not willing to help them meet the costs of treatment. Even the diagnosis by itself often represents such a high expenditure relative to income that many members of the community are deterred from even getting tested to find out whether they have the disease.

The petitioner also wishes to bring into light testimonies of people infected with HCV who have not been able to get any treatment, till date due to the high cost in availing treatment in the state of Nagaland. This person sharing their testimonies is only the tip of the iceberg, regarding the prevailing situation of HCV in the State of Nagaland. It is sated, herein, by the petitioner that the names of the person have been changed to maintain and protect the identity of the individual. The testimonies recorded are produced herein below, in verbatim:

Testimony of Jimmy, Kohima (Name changed)

“I was tested reactive of Hepatitis C, during the year 2012. The first thought that went through my head was that “ am going to die” because I knew treatment for the disease cost 2-3 lakhs rupees and me belonging to a middle class family, for us how hard it is to collect a huge sum of 3 lakhs. For some time I didn’t inform nobody at home all the time carrying the feeling that am going to die. But finally I had to inform them as I didn’t want to die of a curable disease. Now, the most important problem was arranging for cash i.e. treatment money. My parents are small time workers, so arranging a sum of 3 lakhs they have to pull many strings like taking loan on interest, taking loan loans from banks. Finally after arranging the money, I started with my treatment. Even during the treatment I was all the

time depressed by the thought of my parents paying off that amount thought they don't tell me I know they are still paying off that amount that too on interest.

Testimony of John (Name changed)

“When a NGO who work in the field of drug abuse and HIV/AIDS were conducting a screening for Hepatitis C (HCV), I volunteered to get myself tested and was screened. My result tested positive for HCV antibody. I work as a small part time worker at a private firm, so it was far too difficult for me to pay for my treatment and even if I am reactive with the disease I feel I will never be able to get treatment as even my parents they will never be able to pay for the treatment as it is an amount which they would never afford. Though it hurts me that I will not be able to get treatment, but I guess I have to accept the fact that it is something beyond the capacity of me and my parents. So I have been living with the disease for the past many years, and remain untreated till date in spite of treatment options being available.”

Testimony of Robert (Name changed)

“I tested positive for Hepatitis C in 2015. Even till today, I can't think of myself getting treatment. So, if the Govt doesn't come up with something like free Hepatitis C treatment like that of ART for HIV/AIDS people , I will not be able to afford the treatment cost though it has lowered down to almost 25,000/- for the three months course. The reasons being – I am employed but the treatment cost is too much for me and my parents. I have no one who could help me go for treatment. So I continue to live with disease and just hope that someday something comes up and I will be blessed, so I have left all my hope to God as I have mentioned above.”

Only specialist doctors in the State can handle Hepatitis C treatment is neither necessary nor technically correct, and the general lack of such specialists exacerbates the challenges victims face in finding treatment options. HCV can be treated successfully if handled by a trained physician who is knowledgeable in all aspects of care for the disease.

Through this petition, the petitioner also wishes to state that pregnant mother who are infected with HCV has 90% chance of infecting the new born baby, who develop chronic HCV and without treatment progresses to chronic liver disease and liver failure. The symptoms of “the silent killer”, is not apparent at the initial stage but at a later stage only which causes grave liver problems.

Furthermore, higher incidence of HCV in women has been reported from multigravida, where previous pregnancies, hospital admissions, obstetrical surgeries and blood transfusions have lead to an increase incidence of HCV infection among women. The petitioner also states that HCV cases in women are fast increasing due to unsafe injection practices, promiscuity and unsafe sex, unsanitary delivery practices, rising intravenous drug use and usage of unsafe blood products from unregistered blood banks putting their life at great threat. This has been published in Eastern Mirror, dated 27.07.2017, titled, "Pregnant women with Hepatitis C have 90% chance of infecting their new born.

The petitioners on a lot of occasions have deliberated on literacy program of HCV, conducted consultation during World Hepatitis Day over the years, and also urging on the issue to make available treatment for HCV in the state of Nagaland which have been widely published in the media reports. However, till date there have been no effective steps being taken or any positive response being initiated on the issues flagged rather such have only turned to deaf ears.

In an Executive Committee Meeting, dated 20.03.2013, of the NSACS it was discussed on the treatment of HCV and the possibilities of forming a committee for HCV and conduct study on HCV in the state. The Chairman NSACS also suggested the Director of Health and Family Welfare for inclusion of HCV in the department's plan. The meeting also deliberated on reimbursement of the medical expenses incurred on HCV, as initiated by the Manipur government, for the high cost of treatment.

Furthermore, the Petitioner No. 2 and 3 sent a recommendation letter to Respondent No. 1 (The Chief Secretary) on 04.04.2016, highlighting on the prevalence of HCV in the state and the need in tackling the deadly virus, however, nothing fruitful has materialised till date.

The petitioner most humbly begs to bring to the notice of this Hon'ble Court a media report, dated 26.07.2016, tiled, "**With Hepatitis-C becoming curable, doctors call for government intervention for accessible treatment**" published by Morung Express wherein it reported that there has been a rise in the increase of Hepatitis-C cases in the region with a current prevalence of in 1.6% in population wherein, 36 patients were infected, of which 20 were infected with Genotype 3, 9 were infected with Genotype 1 and remaining 7 infected with Genotype 6. The media also reported the importance of the government to introduce more initiatives and programs to make treatment and drugs available to the people.

Furthermore the petitioners states, herein, that to apprise the respondent parties on the staggering and alarming expansion of Hepatitis-C in the state of Nagaland, a workshop

was jointly organized with detailed deliberations and discourse on the issue of HCV was conducted in presence of resource person from NICED (ICMR), Calcutta Medical College, renowned pharmaceutical companies and the state respondents. That after conclusion of the workshop certain recommendations were made towards the state respondents, produced herein below:

The Health Department, Government of Nagaland needs to follow up with the NACO as well as the Ministry of Health, Government of India on launching of Hepatitis prevention and treatment program in the State.

The State Government needs to put up an official correspondence seeking the intervention of the Ministry of Health, Government of India to facilitate operational research with the support from the Department of Health Research and involvement of Indian Council of Medical Research to generate information on disease burden as well as impact of HCV treatment on the quality of lives of people living with HCV

Suggested that the NHM propose Hepatitis program in their AAP (Annual Action Plan)

The Department of Health, Government of Nagaland to have a nodal officer for addressing HBV and HCV issues in the State.

The pharmaceutical companies need to provide their facilities of testing, screening and impart skills and capacity enhancement programs to the Health Department officials at the district level through a memorandum of agreement

However, despite the induction on the glaring and prevailing issues of HCV in the state, the apathy of the state respondents remains in status quo for till date people in Nagaland are dying of preventable and curable HCV. The petitioners also state that these recommendations have failed to see earnest concern from the respondents, failing to secure the life of its citizens. The issues discussed in the workshop were also published in the local dailies; **Eastern Mirror, dated 22.09.2016, "Hepatitis workshop throws up scary number for Nagaland"** and **Morung Express, dated 23.09.2016, "Hepatitis-C virus epidemic expanding in Nagaland"**

The state respondents have shown no political will or seriousness in tackling this viral time bomb. That due to the persistent and prevailing threat a Public Interest Litigation was filed in this Hon'ble Court numbered at PIL No. 2(K) of 2008 by the Positive People Foundation against the state respondent which prayed for including materials on prevention and treatment of Hepatitis-C in its IEC program, to provide for free testing facility at every district ICTC centers in the state of Nagaland, to provide for free Hepatitis-C virus

and treatment. In light of the prayers made in the abovementioned petition, this Hon'ble court vide final order, dated 05.08.2011, disposed of the petition by directing the state respondent to take up the matter with the Government of India for budgetary support in providing facilities for treatment of HCV in the state of Nagaland and further directing the state respondents to chalk out a plan to include materials for prevention and treatment of Hepatitis-C in its IEC program. That despite this order and direction, from this Hon'ble Court, the respondents have failed to take any serious cognizance only portraying the widespread apathy and the callous attitude of the respondents in addressing the issue.

The petitioner wishes to state that other states in India facing the same crisis of Hepatitis-C prevalence have already taken action and that the state of Nagaland has an obligation to provide not only free testing/ diagnosis and treatment for Hepatitis-C but also to undertake prevention and awareness program amass.

Punjab, for example, launched the Mukh Mantri Punjab Hepatitis C Relief Fund, a special State initiative in which medical specialists are trained by the experts of PGIMER Chandigarh and free treatment is provided at 22 district hospitals and three government medical colleges. As of December 2016, Punjab had enrolled approximately 18,000 patients in the program

1. The Tamil Nadu Chief Minister's Comprehensive Health Insurance Scheme provides reimbursement for Hepatitis C treatment.
2. The Manipur State Illness Assistance Funds (MSIAF) cover Hepatitis C treatment costs for the poorest individuals in the state.
3. The government of Haryana provides free diagnostics and treatment to scheduled caste (SC) and BPL families.
4. The government of Mizoram has included sofosbuvir in the list of reimbursable medicines under the Mizoram Health care scheme.

Furthermore, to garner the attention of the respondents on the prevailing issues of HCV in the state of Nagaland, the petitioners have sent a detailed representation letter, dated 17.10.2017, to all the respondent parties highlighting on the grievances put forth, however, till date there has no response nor reply received on the representation.

The petitioners also wishes to state that The Government of India, Ministry of Health and Family Welfare vide letter number D.O. 12043/01/2018- Hepatitis (NCDC), dated 06.04.2018, had intimated to the Principal Secretary (H&FW) of all states and Union Territories that the Ministry had decided to roll out integrated initiative for prevention and

control of viral hepatitis for a period of three years. However, in this roll out program, it has come to the knowledge of the petitioners that the State of Nagaland has not been included in the program despite the high prevalence of HCV in the State.

In light of the governmental apathy at the state which particularly bear on the prevalence of HCV infection in Nagaland, the Petitioners submits that it has no equally efficacious alternative remedy and is approaching this Hon'ble Court through this public interest litigation to protect the right to health (which is a facet of the fundamental right to life under Article 21) of the population of Nagaland.

The cause of action for filing this PIL arises within the jurisdiction of this Hon'ble Court and the same is continuing.

The petitioner has not filed any other petition in any other High Court or in the Supreme Court of India praying for the reliefs sought in the instant PIL.

Prayer

In view of the above mentioned facts and circumstances of the case it is therefore, most respectfully prayed by the petitioners that the Your Lordship may graciously be pleased issue a direction/order/writ in the nature of mandamus or any other appropriate writ on the respondents:

- To admit this writ petition and issue Rule Nisi.
- To set up an Enquiry Committee directing the respondents to call on records if any actions, initiative has been taken to tackle the prevailing status of HCV in the State of Nagaland, if taken, what are the steps, and if not, clarify to this Hon'ble court with sufficient reasoning.
- To ensure that testing and treatment of HCV (including essential diagnostics and medication i.e. DAAs, confirmation of chronic HCV with viral load testing, genotyping etc.) is provided free of cost in the State of Nagaland and any accredited hospitals.
- To identify and adequately publicise the names of hospitals, laboratories, medical stores or any other relevant medical establishments which will provide testing and treatment of HCV (including essential diagnostics and medication) free of cost in the State of Nagaland.
- To ensure that the Primary Health Centre and the Community Health Centre are

adequately equipped and authorized for HCV antibody testing; and referral to public hospitals for further treatment

- To include all the drugs for the treatment of HCV under the essential drug list of the state.
- To include materials on prevention and treatment of HCV in the IEC program for awareness and general mass sensitisation across the State of Nagaland.
- To formulate guidelines for the treatment process of HCV in the State of Nagaland or follow the guidelines for treatment laid down by the WHO for HCV.
- To formulate similar program/ schemes like the RNCTP and NACO to combat the issue of HCV.
- And pass any further order or direction as this Hon'ble Court may deem fit and proper, in the facts and circumstances of the case, in the interest of justice.

Order

05/ 12/ 2018

It appears from the return notice issued to respondent No. 7 that full address was not given, therefore, the petitioner shall take fresh steps by providing full address of the respondent No. 7 so that notice may be sent through registered post with A/D attached.

Ms. K. Kikhi, learned counsel appears on behalf of the petitioner, Ms. V. Suokhrie, learned Addl. Sr. Government Advocate appears on behalf of the state respondents Mr. Z. Kulnu, learned counsel appears on behalf of Mr. Yangerwati, learned C.G.C for respondent Nos. 4 and 5. List the matter after winter vacation.

6. Mrs. XXX vs. State of Nagaland I.A. (Civil) 150/ 2018

Synopsis

The present Public Interest Litigation is being filed under Article 226 of the Constitution of India seeking issuance of writ of mandamus or any other appropriate writ(s), order(s) or direction(s) of this Hon'ble Court to the Respondents, inter alia, due to grave violations and non-implementation of the laws and guidelines by the Respondents laid down by the

National AIDS Control Organisation (NACO), Government of India, various provisions of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act (hereafter known as the HIV & AIDS Act for the sake of brevity), 2017, in true letter and spirit, and several judgments by various High Courts and the Supreme Court of India and seeking directions to Respondents to ensure availability of essential medicines, including Nevirapine, for people living with Human Immunodeficiency Virus (HIV), newborn infants and pregnant women and lactating mothers in the State of Nagaland.

This petition is being filed due to an emergency situation instigated by the failure of the Respondents' in the provision of essential medicines and their inability to maintain vital stocks at Integrated Counselling and Testing Centres (ICTCs) at the Civil Hospital of Dimapur in the State of Nagaland. Further, it has been reported that several other ICTCs and Antiretroviral centres (ARTs) have no stock of Nevirapine and other vital antiretroviral drugs, which are vital for the prevention of infection of HIV in newborn infants. Consequently, since the 1st of September, newborn infants have not been administered this vital syrup due to its non-availability at the Dimapur ICTC. Instead, an adult dosage of Nevirapine, in the form of a tablet, is being broken into four, of which each newborn infant receives one fourth of the whole tablet. As it cannot be ascertained whether patients are receiving the correct dosage, these acts are in grave violation of guidelines clearly set by NACO and the HIV & AIDS Act, putting various lives at risk.

Order

The case is on-going.

Access to Healthcare Services



No ASHA Worker or other medical professional have ever visited the Rohingya camps. Often when they go to Government hospitals, they are asked to show their Aadhaar cards and denied treatment when they cannot produce one.

1.Jafar Ullah & Anr. Vs. Union of India and Anr. (Writ Petition (C) No. 859 of 2013

Synopsis

The present Writ Petition has been filed in the public interest under Article 32 of the Constitution of India, relating to serious violations of the Right to Life, maternal health,

the Right to health and the Right to basic human dignity of women and families of rohingya community from Myanmar who have suffered persecution, violence and displacement and now live in deplorable conditions in temporary make shift settlements in Delhi and Haryana. That the petitioners over a period of five years have submitted three detailed fact finding reports that illustrate the deplorable condition in which the rohingya people continue to live and the complete lack of basic amenities, including, clean drinking, education for children, health facilities, hygiene, maternal health care and basic sanitation.

Facts

It was highlighted on the issues of clean drinking water, sanitation, education, health and subsidized food for the Rohingyas, their children have not been enrolled due to lack of Aadhar card and also the Rohingyas are not able to access health services due to lack of documentation. The pregnant and lactating mothers are not getting the benefits of the health schemes and due to unavailability of ASHA workers and Anganwadi centre; they are also unaware of the benefits of the institutionalized delivery.

The Hon'ble Court taking into account the reflected the report submitted by the Union in the order and also stated that:

1. As far as Nuh Block, District Mewat, Haryana is concerned, the Sub-Divisional Magistrate or the equivalent authority of District Mewat, Haryana and in respect of Kanchankunj, Kalindikunj, Delhi, the concerned jurisdictional Revenue Magistrate, Delhi are appointed as the nodal officers.
2. Parents or any relative or a guardian of a child or a patient can go with a grievance to the Nodal Officer, if any facility, as stated in the Status Report is denied to him/her. The Nodal Officer shall do the needful, as stated in the Status Report.

Order

In pursuance of our earlier order, the compliance Report of the Committee on the present status of health facilities for the Rohingyas staying at Nuh Block, District Mewat, Haryana and Kanchankunj, Kalindikunj, Delhi has been filed. With regard to the habitation, health service delivery, water, sanitation, hygiene, electricity and education in respect of Nuh Block, District Mewat, Haryana, the Report states thus:-

“1. Habitation:

The members visited 2 (two) settlements of Rohingyas within Nuh Block of Mewat District i.e. Ferozpur Namak and Shahpur Nangli. The members of the Rohingya community are residing in Camps made of neat rows of huts with electricity connection and water provision. The hutments are made up of bamboo, plastic sheets (Tirpal) etc. There are open spaces all around and the camps are well spread out.

2. Health service delivery:

The settlements visited have following health facilities in and around the Nuh Block: 1 Sub Centre (SC) Ferozpur Namak, which has recently been made functional as a Health & Wellness Center to provide comprehensive primary health care services (distance from Ferozpur Namak 500 meters)

1. Community Health Centre (CHC), Nuh (distance from Ferozpur Namak - 4 Kms distance)
2. Primary Health Centre (PHC), Nuh (distance from Ferozpur Namak - 4 kms)
3. Saheed Hasan Khan Mewati Medical College – 8 kms away from Ferozpur Namak.

The above health centres are providing all primary, secondary and tertiary health care services as per standard National/State guidelines. The Rohingyas have equal access to these health services as any other citizen in the district. The ANM visits the camps once a week and provides basic primary health care like screening for communicable diseases, ante natal check-up, immunization etc. The ladies of the Rohingyas have home deliveries. On being enquired about its reason, it was stated that they prefer home deliveries rather than going to the hospitals. Only in case of any complication, the pregnant women are taken to the hospitals. The Health services are being provided by trained and competent health care providers. It was observed that the ANM providing outreach services at the visited sites had an experience of over 6 years and had adequate knowledge and skills to meet the health needs of the population. The Primary Health Centre Medical Officer and the Sub Centre ANM also had enough supplies of drugs required for providing outreach health camps. The ANM had detailed knowledge and data of the population required for providing maternal, child health, family planning services. Eligible Couple list and 0-2 year age group children list were maintained by ANM. No Maternal Death or child death was reported. Pregnant women, lactating mothers and children (6 months – 6 years) of the Rohingya community are registered with the Anganwadi worker and have availed benefits under the

Supplementary Nutrition Programme (SNP), medicines like Albendazole, iron folic acid, etc. are being distributed by ANMs and Anganwadis.

Ferozpur Namak camp has a total population of 301, of which 43 children are in the age group of 0-2 years. Shahpur Nangli camp has a population of 507 of which 85 are in the age group of 0-2 years. So, the birth rate is quite high in the population. Even though family planning services are being provided to the eligible couples by the ANM, the usage of family planning methods is low by the inhabitants. Regular screening for communicable diseases are undertaken and no case of TB, Malaria or Dengue was reported from the sites visited. No disease outbreak was reported. Health Camps, Routine immunization programme and intensified pulse polio programme were conducted for these populations at monthly intervals and all records were maintained at the Sub Centre.

For example: (a) Ferozpur Namak: i. On 24.3.2018 Five Pregnant women and Eleven children were immunized.

ii. On 21.4.2018 One Pregnant woman and four children were immunized.

iii. Anganwadi: 25 got SNP, 35 immunizations, 13 pregnant women and 15 lactating mothers availed of other benefits.

(b) Shahpur Nangli: i. On 21.4.2018 in the health camp, there was an OPD of 81 patients of which 21 females and 19 male patients were provided treatment.

ii. Anganwadi: 30 got SNP, 8 immunization, 6 pregnant women and 4 lactating mothers availed of other benefits.

The Rohingyas has access to the free ambulance services for health emergencies provided by the State Government.

3. Water, Sanitation and Hygiene:

The camp at village Ferozpur Namak has one piped water supply provided through the panchayat. The water was found to be potable and the site for water delivery was hygienic and well maintained. The waste water gets drained to a common drain (nullah) behind the camp. In village Shahpur Nangli camp, water supply is provided by tankers through the Panchayat and one water tank with 14000 liters capacity was found in the camp. The tanks were found to be clean and well maintained and no water seepage or water collection around the tank was observed. However, the community requested for one more water tank for summer season for the inhabitants of the Shahpur Rohingyas. Each and every hut in the

site visited had its own toilet and open defecation was not a practice. The overall hygiene of the visited camps was found to be good and there was no collection of garbage/solid waste in open/visible areas.

4. Electricity:

The camp at village Ferozpur Namak, and Shahpur Nangli both had electricity supply. The electricity was available for around 12 hours a day on an average. This was the pattern in the entire district based on the availability of power supply received by the district. Some of the huts had refrigerator, air cooler etc. One of the huts was also converted to a local shop for selling daily utilities which even had a computer installed.

5. Education:

The Committee visited Govt. Secondary School, Ferozpur Namak, where the children of the Rohingyas are studying. There are around 500 children and 19 teachers. In this primary school there are 41 Rohingya children who are studying and all the facilities are being provided to these children similar to Indian citizens without any discrimination. The Rohingya children are given the mid-day meals at-par with the local children. The school administration also provides them all facilities including free books, bags, etc. In the Government Secondary School visited at Ferozpur Namak, 39 children in Class II, 6 children in Class III and one child in Class IV are pursuing their education. The Committee interacted with the class II girl children, who are regularly going to the school. Shahpur Nangli Rohingya settlement had a Madrasa and many prefer to sent their children to Madarsa. Copy of attendance register and relevant photographs are enclosed in Annexures. The Committee also visited another slum in the vicinity, namely Madina Basti inhabited by local Indian citizens. In comparison to the Rohingyas, the overall hygiene and sanitation was not found to be satisfactory. There was no electricity connection. Water supply was scarce even though the inhabitants were living in the area for over 15 years. Outreach services for immunization and ante natal care are being provided to the residents. Three children, present during that time of visit, were found to be home delivered. The inhabitants had valid Aadhaar card and Election ID card.

Concluding Remark:

The Committee had an overall observation that the Rohingyas are not being discriminated

against despite being illegal migrants. They are being provided with basic facilities for health care, water, sanitation and education. The quality and comprehensiveness of the services provided are not less than those provided to the Indian citizens and are within the available infrastructure and resources of the District.” In respect of Kanchankunj, Kalindikunj, Delhi, the Committee has with regard to access to health care system, recorded its findings as under:-
“Access to health care system:-

A. List of Health facilities in the nearby locality is as under:-

- a) MCW Center Madanpur Khaddar (MCD)
- b) Polyclinic Madanpur Khaddar (Delhi Govt.)
- c) SPUHC. Abul Fazal (NRHM) 4 km (Delhi Govt.)
- d) AAMC Abul Fazal Part-2 (3 km) (Delhi Govt.)
- e) AAMC Shaheen Bagh 4 km (Delhi Govt.)
- f) DGD Batla House 7 km (Delhi Govt.)
- g) Rural Health Center of HAH Centenary Hospital (Majeedia) (Pvt.) (2-3 km)
- h) Safdarjung Hospital (10 km) (Central Govt.)
- i) Al Sifa Hospital (6 km) Abul Fazal
- j) Majeedia Hospital (10 km)
- k) Mobile van from Jamia Hamdard (Pvt.) visits the area once a week.

B. Immunization:-

Every month Delhi Government Dispensary (DGD) Srinivaspuri conducts 10-12 sessions of immunization at 10 different sites covering all blocks of JJ Colony and Kanchankunj.

Most of the children were found to have received age appropriate immunization. Cards of some children were also verified. ANMs visit the camp for vaccinations during pulse polio campaign. Routine Immunization services are mainly provided by the MCW Center Madanpur Khaddar, nearby health center.

C. Maternal Health:-

ANC care and investigations are being provided at nearby health facilities/Centers. Mother

and child protection (MCP) Cards were examined and found to bear MCTS/RCH number (Mother and child tracking system). Birth certificates issued by MCD to the children were also examined. However, most of the deliveries are taking place at home and only complicated cases go to Safdarjung Hospital, which is about 10 km away. When enquired about the factors for home deliveries, the response received was that they prefer not to go to any health facility for normal delivery.

D. Family Planning:-

In spite of the access and availability of all family planning services being provided by the local health authorities, acceptance of family planning methods was limited.

E. Outreach services:-

ANM for Maternal and Family Planning Community Outreach services has also been made available by the local health authorities. In addition, Mobile Health Van comes once a week from Jamia Hamdard (Pvt.) centres to treat minor illness. For major illness, the inhabitants visit nearby public/trust/private health facilities. There is no reported incidence of Maternal or Child death in the last 5 years.”

It is submitted by Mr. Colin Gonsalves, learned senior counsel and Mr. Prashant Bhushan and Ms. Sneha Mukherjee, learned counsel appearing for the petitioners that school children are not getting books and other benefits. They have also projected that as far as the health care system is concerned, the facilities are denied to them, because of lack of proper identity.

Dr. Rajeev Dhawan, learned senior counsel would submit that human rights are extremely sacred and the same have to be given full play in the completest sense in respect of a non-citizen also, for Article 21 of the Constitution which embraces human rights and human rights correspondingly responds to the said article, and hence, there cannot be any discord between the two concepts.

Dr. Ashwini Kumar, learned senior counsel appearing for the petitioners in Writ Petition (Civil) No. 886/2017 would submit that India being a civilized and developed democracy has to stand by the fundamental concept and essential conception of human rights.

Mr. P.V. Dinesh, learned counsel for the petitioners in Writ Petition (Civil) No. 262/2018 with anguish and concern, submitted his experience in a camp. We do not intend to enter into all the issues that have been canvassed before us. We may clearly state that the same

shall be addressed to at the time of final hearing of the writ petitions and the interlocutory applications. However, for the present, we issue the following directions:-

(i) As far as Nuh Block, District Mewat, Haryana is concerned, the Sub-Divisional Magistrate or the equivalent authority of District Mewat, Haryana and in respect of Kanchankunj, Kalindikunj, Delhi, the concerned jurisdictional Revenue Magistrate, Delhi are appointed as the nodal officers. The said position is accepted by Mr. Tushar Mehta, learned ASG.

(ii) Parents or any relative or a guardian of a child or a patient, can go with a grievance to the Nodal Officer, if any facility, as stated in the Status Report is denied to him/her. The Nodal Officer shall do the needful, as stated in the Status Report. At this juncture, Mr. Kunal Chatterji, learned counsel for the West Bengal Commission for Protection of Child Rights submitted that there is difficulty in uniting the children of Rohingyas who are separated from their parents. Mr. Tushar Mehta, learned ASG shall obtain instructions in the matter and if there is any problem in this regard, the concerned authority of the Union of India can apprise the Commission so that an appropriate view can be taken.

Let the matter be listed on 23.8.2018

Access to Adequate Nutrition

Government has accorded high priority to the issue of under nutrition and is implementing several programmes of different Ministries/Departments through State Government/UT Administration, which have the potential to improve the current nutritional situation in India.

Currently major nutrition supplementation programs in India are as follows:

- a) Integrated Child Development Services Scheme (ICDS);
- b) Mid-day meal Programs (MDM);
- c) Special Nutrition Programs (SNP);
- d) Wheat Based Nutrition Programs (WNP);
- e) Applied Nutrition Programs (ANP);
- f) Balwadi Nutrition Programs (BNP);
- g) National Nutritional Anemia Prophylaxis Program (NNAPP);
- h) National Program for Prevention of Blindness due to Vitamin A Deficiency;
- i) National Goiter Control Program (NGCP)

The history of the respective programs, their beneficiaries, objectives, activities, organization, and evaluation are detailed. The ICDS beneficiaries are children below 6 years, pregnant and lactating mothers, and women aged 15-44 years, who are provided the following: supplementary nutrition; immunization; health check-ups; referral services; treatment of minor illnesses; pre-school education to children aged 3-6 years.

The question that can be raised is whether these policies and programs been properly implemented or have not been implemented. HRLN as a network has taken up several cases to address this issue which clearly states that the schemes and policies have not reached most of the beneficiaries. Below mentioned are few of the cases which will give a picture of the current situation of the schemes launched by the government.

1. Smt. Mutum Romanandi Devi Vs. State of Manipur & Ors, WP(C) NO. 28 of 2017

Synopsis

In this case the petitioner was not provided with the basic amenities to be provided under maternity benefit under the National food Security Act, 2013.

Facts

According to the case, the petitioner, who is a pregnant woman belonging to the category of Priority House Hold as per Ration Card issued by the Consumer Affairs, Food & Public Distribution, Government of Manipur. The ration card is in the name of Konthoujam Bimola Devi, who is the mother-in-law of the petitioner. Since the petitioner is pregnant, expecting delivery by 5-3-2017, used to go to medical centres for regular prenatal check up. During regular check up the Doctor prescribed different kind of medicines and has also advised to have nutritional food. In that situation, an application was submitted to the Director, Department and Social Welfare, Government of Manipur to provide necessary nutritional support and also maternity benefit as provided under Section 4 of the National Food Security Act, 2013. According to the learned counsel no such decision has been taken by the Director, Department of Social Welfare, Government of Manipur, as a result of which the petitioner is being denied with the benefit provided under the said Act.

Orders

18-01-2017

In view of the above facts and circumstances as stated above, this writ application is disposed of directing the respondent, the Director, Department of Social welfare, Government of

Manipur, to take decision over the representation filed for the said case, to the effect stated above, within a fortnight from the date of receipt of a copy of this order.

Thus, this application stands disposed of.

In view of the submission of the learned counsels for both the parties, this Court is of the view that this writ petition can be disposed of in terms of the aforesaid order with similar direction.

Accordingly, the present writ petition is disposed of with the direction to the respondent No. 2, Director, Social Welfare Department, Government of Manipur to take a decision over the representation filed by the petitioner on 9-11-2016 as directed in W.P.(C) No. 811 of 2016 within a fortnight from the date of receipt of a copy of this order.

2. Alka Rajputh Vs. State of Assam & 6 Others, WP(C) No. 2504/17

Synopsis

In this case the petitioner, was six months pregnant working in the tea gardens of Assam, was not provided with maternity benefits under JSSK under National Health Mission.

Facts

Alka Rajputh is a resident of Dhullie tea garden in Sonitpur district of Assam. She is about 20 years and belongs to a BPL family. She delivered her first child on the 22nd of July, 2016, at Dhullie Tea Garden Hospital which is running on a PPP basis. Her child weighed only 2 kgs at birth. The petitioner evidently suffers from anemia and is weak. She did not receive proper nutritional support from the State through Anganwadi. Only on occasion during her pregnancy she received 2 kgs of rice, 250 gms of pulses and 1 kg Sattu. After pregnancy, she received another 2 kgs of rice. Other than this, her ANCs weren't proper and her MCP card was not filled at all.

Also, she received only 30 IFA tablets from the local ASHA. She now suffers from malnutrition and her husband merely earns Rs. 3500 per month. Consequently, the petitioner is often forced to skip meals or eats simply rice. Also, she did not receive the money under JSY and the Mamoni schemes as well as the Mamata kit.

*Orders***DATE OF ORDER: 29-05-2017**

BEFORE HON'BLE MR. JUSTICE MICHAEL ZOTHANKHUMA:

Heard Ms. D Ghosh, counsel for the petitioner and Mr. Y Doloi, Additional Advocate General, Assam. The petitioner by way of this writ petition claims payment of Rs.1400/- under the Janani Suraksha Yojana Scheme. The other claim made by the petitioner is with regard to payment of Rs.6000/- under Section 4(b) of the National Food Security Act, 2013.

The petitioner also claims payment of Rs.1000/- for completing her 1st and 3rd ante-natal checkups. The counsel for the petitioner submits that while the petitioner was given Rs.500/- only for her 2nd ante-natal checkup, she has not paid any amount thereafter, as the Asha worker did not take her for 1st and 3rd ante-natal checkups, due to the negligence of the Asha worker. Mr. Y Doloi, Additional Advocate General has submitted a letter dated 20.05.2017 issued by the National Health Mission, office of the District Health Society, Sonitpur which states that the petitioner was given Rs.500/- for her 2nd ante-natal checkup. The petitioner was not paid any other amount for the 1st and 3rd ante-natal checkups as the fund requirement was not made to the NHM by Dhullie Tea Garden.

The letter dated 20.05.2017 also states that the petitioner was not given Mamata Kit as it was out of stock. Mr. Y Doloi, Additional Advocate General submits that Rs.1400/- as claimed by the petitioner under the Janani Suraksha Scheme has been given to the petitioner. He submits that the respondents would consider giving the Rs.1000/-, which the petitioner was entitled under the 1st and 3rd ante-natal checkups. He also submits that Mamata Kit will be given to the petitioner as and when the stock is available in the Tea Garden Hospital.

Mr. Y Doloi, also submits that the petitioner's claim for payment of Rs. 6000/- as per Section 4(b) of the National Food Security Act, 2013 will be considered by the Director of Social Welfare as the petitioner's representation dated 04.02.2017 on that count has not been decided till date. On hearing the counsel for the parties, this Court directs the Director of Health Services to issue to the petitioner Mamata Kit within a period of 1 (one) month from the date of receipt of a copy of this order.

The Director, shall consider the petitioner's letter dated 04.02.2017, with regard to payment of Rs. 1000/-, which she would have received under the 1st and 3rd ante-natal checkups and pay the same to the petitioner if she is so entitled to the same.

The Director of Health Services shall take a decision on the matter within 1 (one) month from the date of receipt of this order. The Director of Social Welfare Department shall consider the petitioner's representation dated 04.02.2017 with regard to payment of Rs.6000/- under Section 4(b) of the National Food Security Act, 2013 and if found eligible shall make payment of the same within a period of 1 (one) month from the date of receipt of a copy of this order.

The writ petition is accordingly disposed of.

3. Pranita Kalita Vs. Union of India & 13 Others; WP(C) No. 7910/16; and Pranita Kalita Vs. Sri SS Meenakshi Sundaram, Director, Directorate of Social Welfare; Contempt Petition(C) No. 224/2017 Gauhati High Court

Synopsis

Malnutrition among children and women is one of the serious issues of concern in India. The proportion of undernourishment among children and women in India is highest as compared to the rest of the world. One in three women in the age group of 15 – 49 years has a Body Mass Index (BMI) below 18.5 indicating severe nutritional deficiency and under-nutrition.

Among pregnant women, 58% are anemic. Anemia increases the risk of maternal deaths. Hunger is also one of the most basic of human deprivations. As per the report, "The State of Food Insecurity in India" by Food and Agriculture Organization of the United Nations (FAO), there were still 194.6 million undernourished people in India in 2014-16, which constitutes 15.2 percent of India's population. This number was 210.1 million in 1990-92. Thus, India has failed to achieve its MDG hunger target of halving the proportion of people who suffer from hunger, and the report reflects that India is making slow progress in the direction. Also, India has the second highest estimated number of undernourished people in the world. Hunger is a basic feeling in all living beings. It can drive one to extremity. It has direct implications on health. A person's health is directly dependent on one's food habits. Deprivation of food is thereby a violation of a person's Right to Food as well as Right to Health, both of which are parts of Article 21 of the Constitution of India. Thus, the petitioner is filing this petition for the violation of her and her child's Fundamental Rights under Article 21.

The petitioner is a citizen of India and a permanent resident of Nalbari District of Assam.

This writ petition was filed as there was violation of Article 21 of the Constitution of India. Article 21 provides right to life and health. Moreover, this writ petition was filed as a result of non implementation of the maternity benefits provision under National Food Security Act (NFSA), 2013, and failure to implement the maternal health schemes under the National Health Mission specifically Janani Suraksha Yojana (hereinafter referred as JSY), Janani Sishu Suraksha Karyakram (hereinafter referred as JSSK) and Mamoni and Mamata Schemes.

The petitioner belongs to an economically deprived class of the society. The husband of the petitioner, Rajen Kalita, runs one small betel nut shop at Lamb Road, Guwahati and earns around Rs. 130/- per day which amounts to Rs. 4,000/- per month approximately.

On 21st September, 2016, the petitioner gave birth to a girl child at M.M.C Hospital, Panbazar, Guwahati. On that day when the petitioner's labour pain started, her husband called for an ambulance dialing 108 but no one answered the phone call. Then the husband of the petitioner hired an auto to carry the petitioner to the hospital which cost him Rs. 200/- (Rupees Two Hundred). The non-availability of ambulance service is the violation of the Janani Sishu Suraksha Karyakram (hereinafter referred as JSSK).

She also did not receive any cash assistance under the Mamoni Scheme¹. It is a State sponsored scheme under which cash assistance to Pregnant Women for Nutritional support @ Rs. 1000/- in two installments is being paid. "Mamoni" is a scheme which encourages pregnant women to undergo at least 3 ante-natal checkups which identify danger signs during pregnancy (needing treatment) and offer proper medical care.

When she gave birth her child too did not receive the Mamata kit². The Mamata scheme

1. Mamoni Scheme of Assam Government: Mamoni is a Government of Assam scheme for pregnant women. It was launched in 2009 under Assam Vikash Yojana of Govt of Assam. The objective of the scheme is to encourage pregnant women to undergo at least 3 ante-natal checkups which are helpful in identifying danger signs during pregnancy. The process of Mamoni Scheme starts during the First Registration of the pregnant women. At that time, the Mamoni booklet containing details on antenatal, natal and postnatal care is given to the pregnant women. During her 2nd ANC, an account payee cheque of Rs. 500 is given. Another Rs. 500 cheque is provided to the women during her 3rd ANC. The small financial aid is provided for expenses related to nutritional food and supplements; <http://www.assams.info/assam/mamoni-scheme#ixzz5OLcFBKGQ> ; Last Accessed on 16.08.2018

2. Mamta Scheme for Pregnant and New-born baby: <https://govinfo.me/mamata-scheme/> Last accessed on 16.08.2018

was introduced by the Government of Assam. The scheme seeks to reduce IMR and MMR by insisting on post-partum care at the facility level to the mother and newborn. Under the scheme, all new born babies in public health facilities are to be given a free gift baby hamper called 'Mamata Kit' which consists of baby mosquito net, baby soap, baby talc, baby oil, blanket, towel, flannel cloth, baby mackintosh, greeting card with a plastic kit bag.

Facts

This writ petition WP(C) No. 7910/16 was filed under Article 226 of the Constitution of India in the wake of petitioner's violation of government schemes (National Health Mission including the Janani Shishu Suraksha Karyakram (JSSK), Mamoni Scheme and Mamta Scheme) and National Food Security, 2013. The petitioner filed this petition to seek for compensation and the due cash entitlements. That the petitioner belongs to an economically deprived class and her husband owns a small betel nut shop. The petitioner was pregnant and was in her final trimester.

On 21st September 2016 when she started getting labor pain, her husband called for an ambulance, the call was not received and they had to hire an auto to the hospital. The non-availability of transportation is in clear violation of Janani Scheme. The petitioner has not received any cash assistance due to her under Mamoni scheme, neither has she received the Mamta kit, to which she is entitled to under the Mamta scheme. The petitioner has also not received Rs. 6000 under IGSMY scheme as nutritional support and nutritional support due to her under Section 4(a) of the NFSA.

Orders

16/07/2016

The above case is pending but in the interim, an order was passed to pay Rs. 3000 to the petitioner under the IGMSY within one week of receipt of order. Representation was filed but still, no payment was made to the petitioner. Thereby a contempt petition was filed subsequent to which, the petitioner finally was paid Rs. 3000 as per the order.

4. Peoples Union for Civil Liberties vs. Union of India, and Others, W.P. (C) 227/2015

Synopsis

By way of this public interest petition under Article 32 of the Constitution of India, the petitioner PUCL seeks intervention of the Supreme Court for enforcement of the National Food Security Act, 2013 and immediate provision of entitlements therein. This petition was filed in May/June 2015 to challenge non-implementation of NFSA even after two years of it coming into force.

When this petition came up for admission before the social justice bench, the judges allowed the petitioners to choose only two prayers from the petition and we had to restrict the scope of the petition to prayers b) and j) on non-implementation of PDS and maternity benefits under NFSA. Over the period states have now started implementing PDS, to whatever extent, and the related prayer has become infructuous. The Court is still hearing this case on the prayer of maternity benefits where the major issues are broadly that of: non-implementation of the scheme, conditionalities under the scheme and inadequate budget allocations.

Facts

The PUCL had filed Writ Petition (Civil) no, 196 of 2001 (PUCL vs. Union of Indian & Ors.) in respect of the Right to Food of poor and destitute people of India, and particularly those who are below the poverty line. The Supreme Court has already made a considerable number of orders in respect of the entitlements of the poor for subsidized grain, supplementary nutrition, the midday meal, maternity benefits, and pensions in the famous Right to Food case. Some but not all schemes and entitlements that were the subject matter of this petition have now been subsumed and become legal entitlements under the National Food Security Act, 2013. PUCL filed for enforcement of provisions and entitlements and publication of 'final lists' of Socio-Economic Caste Census 2011 for identification of priority and AAY households under the Act.

The background to this petition is that the PUCL had first filed IA no. 135 in the original right to food case (196 of 2001). At that time, the primary reason why states were not able to carry out its identification exercise under NFSA for PDS ration cards was that the Central Government had not released its latest SECC census data. The main prayer in

IA 135 was for the Ministry of Rural Development to release SECC data and notice was issued on it in November 2014.

It was later realized that merely having the SECC data would not necessarily lead the states to start the identification process and start implementing the NFSA. It was also felt that we need to highlight that other entitlements of NFSA, apart from PDS, are also not being fully implemented (especially maternity benefits). We, therefore, filed another IA no. 137 on NFSA non-implementation covering all entitlements in February 2015. This IA covered: release of SECC data, completing identification process for PDS beneficiaries, framing and implementing a universal maternity benefit scheme, fully implementing ICDS and MDM, providing infrastructure: kitchen, sanitation and drinking water facilities in Anganwadis and schools, and making adequate budgetary allocations for implementation of different provisions of the Act.

It is relevant to mention here that Justice Thakur, who headed the bench hearing the main right to food case at the time, had seemed keen to dispose of the petition for being obsolete in light of the NFSA coming into force. The new IAs was being filed to revive our earlier prayers in older applications in terms of the new Act.

When these IAs came up for hearing, the judges compared the two IAs and found that the prayer on SECC was identical and the issue was covered under the more comprehensive NFSA IA. The judges therefore got us to withdraw the SECC IA and dismissed it. Coming next to the NFSA IA, judges said that the issues are expansive and fit for a fresh writ petition which can be filed. The NFSA IA was accordingly withdrawn and converted into a fresh writ petition.

Order

11.03.2016

Mr. Colin Gonsalves, learned senior counsel appearing for the petitioner. Let notice be issued in this writ petition to other respondents with reference to prayers (b) and (j) returnable on 5th April, 2016. The counsel for the petitioner is at liberty to serve on the Standing Counsel for the respective States.

11.04.2017

Learned counsel for the petitioner seeks some time to place some additional documents. Learned Additional Solicitor General says that a Scheme has been prepared for implementing

Section 4(b) of the National Food Security Act, 2013. He says that the Scheme will be finalized in consultation with various State Governments to ensure full implementation of the Act. We direct that the needful be done within eight weeks. 4 List the matter on 11th July, 2017.

21. 10. 2018

List the matter in the month of January 2019.

5. Chhattisgarh Sarv Mazdoor Kalyan Samiti Vs. State of Chhattisgarh & 3 Ors. W.P. PIL no. 63/ 2018

Synopsis

In view of the above it is most respectfully prayed that this Hon'ble Court maybe pleased to:-

Issue a writ of mandamus directing the respondent authorities to change the ration card status of the families listed out in the petition from 'Priority Households' to 'Antyodaya Households'. lack of availability of foodgrains at subsidised prices to which they are entitled to has caused great misery to families. The arbitrary denial of the 'Antyodaya Household' status has cause a great hardship. Because, a recent study was conducted on "Exploring health inequities amongst Particularly Vulnerable Tribal

Groups: Case study of Baiga in Chhattisgarh" in Kabirdham District. The study was conducted by Public Health Resource Network, in collaboration with State Health Resource Centre Raipur, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum and Astha Samity Kabirdham. The study showed very high levels of malnutrition among Baiga children under five years of age. Underweight and stunting among these children was 1.5 times more than the state average. The proportion of undernourished Baiga women and men was double that of Chhattisgarh state average while illness was nearly six times more than that of rural Chhattisgarh average with more women than men reported ill health issued to the above families but to no avail. The Petitioners had approached the District Collector with the aim of resolving the issue under internal grievance redressal mechanism provided for under Chapter X of the act read with scheme notified under the Chhattisgarh Lok Sewa Guarantee Act, 2011, however, no action has been taken by the respondent Authorities. The plight of

the families of the Baiga Community have been widely highlighted by newspaper reports. However, the respondent authorities have turned a blind eye to the financial predicament of the above families.

Facts

The present PIL has been filed challenging the Decision of the (Ration Card Issuing Authority) classifying 41 families as 'Priority Households' in granting them ration cards to avail benefits under section 3 of the Act. The above families belong to the 'Baiga' community and have been enlisted as 'Antyodaya Households' under rule 5(2) of the rules notified on 23.01.2017 by the State Government under section 30 of the Act. Under the said rule 'Baigas' have been identified as 'Antyodaya Households' for the purposes of the Act.

Order

20/ 07/ 2018

This writ application is disposed off with a direction to the collector- Kabirdham to take cognizance of the grievance raised in the letter dated 24/ 10/ 2017 addressed to him which is annexure P/4 and pass appropriate direction preferably within a period of eight weeks from the date of production of the copy of this order.

6. Sauradeep Dey Vs. The Union of India & 2 Ors. PIL 7/ 2018

Synopsis

The petitioner's colleagues had visited the Tinsukia district during the first ten days of November, 2017, and carried out a fact-finding by visiting thirteen Anganwadi centres and one office of the Child Development Project Officer and interacting with several pregnant women and lactating mothers. The objective of the fact-finding was to analyse the extent of benefits the entitled beneficiaries are able to avail from the Anganwadi system.

During the fact finding it was observed that much of the provisions of the National Food Security Act, 2013, relating to provisions from the Anganwadi are being improperly implemented or not being implemented at all.

Prayer

In view of the points stated above, it is therefore, prayed that this Hon'ble Court may graciously be pleased:-

- i. to direct the respondents to bring uniformity across the state in the implementation of the Sections 4 and 5 of the National Food Security Act, 2013, and ensure that the provision of supplementary nutrition to the beneficiaries is sufficient in quantity and quality;
- ii. to conduct a physical assessment of the Anganwadis across the state and then take steps to ensure that all anganwadis are equipped to fulfill the objective of providing conditions necessary for pre-school children's psychological and social development through early stimulation and education. Stress should be laid on the availability of safe drinking water, clean toilets separate for boys and girls, electricity connectivity and provision of fans and adequate lighting wherever required;
- iii. to direct the respondents that Section 4(b) is implemented in its true letter and spirit across the state and that all eligible beneficiaries are provided the maternity benefits under the scheme with effect from 1st of January, 2017; and
- iv. to pass any other such order/direction/writ as this Hon'ble court may deem fit and proper in the interests of justice.

Order

11/ 04/ 2019

Heard Ms. D. Ghosh, learned counsel for the petitioner. Also heard Mr. T.C.Chutia, learned Additional Senior Government Advocate, Assam, appearing for the respondent No.2 and Ms. A. Das, learned counsel, appearing for the respondent No.3. Though the learned Additional Senior Government Advocate would submit that the provision of the Act is being implemented, the same is disputed by the learned counsel for the petitioner. In that regard though requisite details are not available, the learned counsel for the petitioner refers to the report at Annexure-2 to the writ petition, wherein a study was stated to have been conducted in respect of different Anganwadi Centres named therein. Through the said report, the lacuna in implementation of the provisions of the Act is referred. In that view, the learned Additional Senior Government Advocate to take note of the report and secure instructions with regard to the Anganwadi Centres, at least as an instance by taking

note of one or two Anganwadi Centres, to indicate the factual position and if in fact the implementation of the Act has been done, the details relating to such Anganwadi Centres be furnished to this Court.

To enable the same, list after 6(six) weeks.

Implementation of ICDS scheme and establishment of Anganwadi Centres



Non functional Anganwadi Centre, Tiwari Gaon, Arunachal Pradesh

1. Guddu vs. NCT of Delhi & Others, W.P. (C) 10446/2015

Synopsis

The present petition was filed for access to, reproductive health care adequate nutrition, and information about contraceptive services to the residents at Chilla Kahadar and benefits to

be provided at the Anganwadis under the ICDS programme in village Chilla Khadar. The women and children living in Chilla Khadar are homeless and the family cluster does not have access to basic health requirements and the government schemes that are designed for marginalized populations. Without these schemes, the cluster risks high maternal death rates and complications. Women and children residents urgently require health entitlements, such as adequate food for pregnant or nursing mothers, young children and the malnourished. That the position with regard to the working of the ICDS programme as well as the functioning of the Anganwadis has substantially improved after filing of the writ petition.

Facts

This PIL for the community Chilla Khadar homeless cluster in New Delhi where women do not have access to community's Anganwadi Centres, which do not provide residents with supplemental nutrition, basic health services, and preschool education in violation of the Integrated Child Development Scheme (ICDS). In one area of the community, families collect donations to provide biscuits for young children. In the interim, the PIL prays for vaccination camps and mobile nutrition vans for pregnant women, lactating women, and children. The petition also demands fully functional Anganwadi Centres, safe drinking water, enrollment in girl child schemes, and antenatal care.

The Chilla Khadar clusters are located on the banks of the Yamuna River. Since the Yamuna occasionally floods, the residents build thatch roof housing and temporary residencies in order to live on the fertile land. The majority of Chilla Khadar residents work as farmers earning meagre wages. Many farmers have lived in the cluster for decades. Chilla Khadar Nangli, further referenced as Nangli, has two Anganwadi Centres (AWC) which were opened on 01.05.2015.

The Petitioner and a team of activists conducted a fact finding and visited the Centres on 28.05.2015, and observed that the AWCs do not meet the minimum requirements for services, infrastructure and staffing under the Integrated Child Development Services (ICDS). The Centres operate out of Rainsbaseras. Another visit to the community in August 2011 revealed that the AWC at Nangli now operates out of a rented jhuggi. On 11.09.2015 after the fact finding, a group of social activist along with the petitioner went to visit the Chilla Kadar Community. In Nangli community, besides the children from 00 months to 09 years, it was observed that the adolescent girls were not availing the schemes under the ICDS. Same was the case for pregnant and lactating mothers. The team also went to meet

the Child Development Project Officer to discuss the issue on setting up an Anganwadi Centre in Hanuman Mandir which was responded back with a negative reply due to “safety reasons” on the grounds that the particular area compromises the safety of the Anganwadi workers. This reason given is in pure abdication of one’s duty and evading the obligation of setting up an Anganwadi Centre under the ICDS scheme.

As such the fundamental right to life, under Article 21 of the Constitution, of the residents of Hanuman Mandir has been violated. Without an adequate building, access to equipment or required staff members, the AWC in Nangli fails to provide supplemental nutrition, basic health services, and preschool education to women and children in the community. The Respondent’s failure to ensure the guarantees in the Integrated Child Development Services Scheme (ICDS) violates residents’ rights to life, health, food, and education enshrined in the Constitution of India. It was also observed that the adolescent girls and the pregnant and lactating mothers were not availing the schemes under the ICDS. Another community of Chilla Khadar, located near Hanuman Mandir, is home to 350 families. The residents of Hanuman Mandir lack electricity, drinking or bathing water, sewage, toilet systems and roads.

Orders

25.01.2017

W.P. (C) Nos.509/2017 & 632/2017

Mr. Satyakam, learned ASC for GNCTD accepted notice in W.P.(C) No.509/2017 and Mr. Sanjoy Ghose, the learned ASC for GNCTD accepted notice in W.P.(C) No.632/2017. The counter affidavits are to be filed within four weeks from today.

**W.P. (C) Nos.10446/2015, 804/2016, 2177/2016, 5137/2016, 8827/2016,
9008/2016 & 10233/2016**

Various issues relating to functioning of Anganwadi Centres in different zones of Delhi have been raised in this batch of petitions. Pleadings be completed by all the parties before the next date of hearing. We also request the learned Standing Counsel for GNCTD to prepare a chart specifying the relief sought in each writ petition so as to enable proper appreciation of the issues involved. Shri Sanjoy Ghose, the learned ASC for GNCTD undertakes to file such chart in coordination with the other counsels appearing in the petitions. The same be filed within four weeks from today.

10.08.2017

1. This bunch of writ petitions have been filed by the petitioners complaining against the lack of fully functional Anganwadis in slum clusters including the clusters of Hanuman Mandir; Chilla Khadar; Seelampur; Mansarover Park and Sanjay Camp.
2. Today Mr. Gautam Narayan, Additional Standing Counsel for GNCTD has handed over a brief note regarding status of Anganwadis as well as benefits provided at the Anganwadis under the ICDS programme in village Chilla Khadar. Additionally, a chart has been handed over setting out the status of the implementation of the ICDS programmes in the Anganwadis situated in the slum clusters which are subject matter of these four writ petitions.

Both these documents are taken on record. 3. It appears that the grievances made by the petitioners are being addressed by the respondents. It is admitted by Ms. Sija Nair Pal, ld. counsel for the petitioners that the position with regard to the working of the ICDS programme as well as the functioning of the Anganwadis has substantially improved after filing of these writ petitions. Page 3 of 4 Ms. Nair also submits that the working of the Anganwadis is being monitored by the GNCTD at the highest level inasmuch as the Deputy Chief Minister of Delhi has personally inspected the Anganwadis and is monitoring their working. 4. In view of the above, these writ petitions need not detain this court any further. Needless to say, the respondent no.1 shall ensure that the Anganwadis and the ICDS programmes are maintained and working in right direction and all necessary steps are taken by the respondent no.1 for implementation of the scheme.

2. Nirmal Gorana vs. Department Of Health and Family Welfare and Ors. W.P. (C) 826/2018

Synopsis

The present petition was filed for access to, reproductive health care adequate nutrition, and the Anganwadi Centres in the Badarpur area of Delhi are being deprived of the benefits of the Integrated Child Development Scheme (ICDS) and the other schemes of the Government for the reason that the Government of NCT of Delhi has been unable to deploy ASHA workers and not effectively implementing the other ICDS schemes.

As a result, the residents of this area are being deprived of the key maternal and child related healthcare schemes under the National Health Mission, 2015 including the Janani

Suraksha Yojana (JSY), 2005; Janani Shishu Suraksha Karyakaram (JSSK), 2011 and ICDS scheme, 1975. to ensure availability and functionality of ante-natal, intra-natal and post-natal health care services, create awareness about maternity benefit schemes, ensure availability of ASHA (Accredited Social Health Activist) worker, proper functioning of and awareness about existing Anganwadi Centers (AWCs) at Bhat camp, Badarpur.

Facts

A fact-finding mission including Social Activists and a lawyer visited Bhat camp at Badarpur where it was observed that the area had a history of cases of infant death, considerable number of deliveries at home, non-availability of ASHA worker in the area and no early registration of pregnancy at Anganwadi centers. Majority of the women who were interviewed demonstrated a lack of awareness regarding healthcare measures, institutional delivery and other myriad schemes by the government as there was absence of ASHA at the area and no assistance from the Anganwadi workers in this regard. Due to non-availability of ASHA workers in the Bhat Camp there persist a sheer lack of awareness amongst the residents of the slum cluster.

The residents are unaware of the benefits of institutional delivery, various risks in case of delivery at home, maternal health care services available to them vide various government schemes for institutional delivery, free delivery, free ambulance services, free antenatal and post-natal check-ups, free treatment for sick new-born etc., ante-natal and post-natal care, pregnancy related matters, family planning, contraception methods etc. But due to the lack of awareness about these maternity benefit schemes and unavailability of services under the scheme they do not get regular check-ups done, do not take proper nutrition or receive any immunization and are forced to give birth at home which have resulted in deaths of infants. As a result, they are at a high risk of having unsafe deliveries, miscarriages, cases of infant death, lack of nutrition which may also lead to increase in infant and maternal mortality rates in the area. Due to the non-availability of ASHA, there is no awareness regarding various maternity benefit schemes of the government, ANC, PNC, institutional delivery and other facilities available to women in the community. Moreover, due to the non-availability of ASHAs, the women are dependent on unskilled birth attendants who charge high fees ranging from Rs. 1000 to Rs. 2000.

*Order***29.01.2018**

1. This writ petition contends that the Anganwadi Centres in the Badarpur area of Delhi are being deprived of the benefits of the Integrated Child Development Scheme (ICDS) and the other schemes of the Government for the reason that the Government of NCT of Delhi has been unable to deploy ASHA workers. The second grievance expressed in the writ petition is that the ASHA Workers are not effectively implementing the other ICDS schemes. As a result, the residents of this area are being deprived of the key maternal and child related healthcare schemes under the National Health Mission, 2015 including the Janani Suraksha Yojana (JSY), 2005; Janani Shishu Suraksha Karyakram (JSSK), 2011 and ICDS scheme, 1975.
2. Appearing on advance notice, Mr. Sanjoy Ghose, Addl. Standing Counsel for the Govt. of NCT of Delhi informs this court that the respondent nos. 1 to 3 are aware of the urgency of the matter and that despite best efforts, it has not been able to recruit trained ASHA workers for the Bhat Camp with regard to which the petitioner has made a grievance. Mr. Ghose informs us that earnest efforts in this regard are underway and that the steps to recruit trained ASHA workers wheresoever needed would be expeditiously completed. It is submitted by Mr. Ghose that the respondents are conscious of their responsibilities and for this reason; ASHA Workers from other areas of Badarpur are being diverted to the Bhat Camp to ensure that no citizen suffers in any manner. We take this statement on record. It is expected that the respondent nos. 1 to 3 shall undertake the needful within a period of three months from today.
3. The respondents shall also ensure that the grievance regarding implementation of the other ICDS Schemes including the immunization programmes is looked into, examined and appropriate steps in this regard are taken immediately.

3. Rosemary Dzuvichu Vs. The State of Nagaland PIL No. 8 (K) of 2018*Synopsis*

The Petitioner is approaching this Hon'ble Court invoking the Writ jurisdiction under Article 226 of the Constitution of India by filing the instant Public Interest Litigation (PIL) on behalf of the citizens of the State of Nagaland. The present PIL seeks effective

implementation of the guarantees under the Integrated Child Development Services (ICDS) and National Food Security Act, 2013 in Anganwadi Centre across the State of Nagaland.

In 1975, the Ministry of Women and Child Development recognised the immediate need to address alarming rates of malnutrition and underdevelopment of children across India. Consequently, the ICDS was launched, representing the most comprehensive response and bundle of services for the direct benefit of children, newborns, pregnant women and adolescents. Its six service bundle included a focus on the provision of supplementary nutrition, immunisation, health check-ups, health referral services, nutritional and health education programs and preschool developmental learning activities. Anganwadi Centres were assigned the role as the hub for the provision of these various services. The ICDS was bolstered by the guarantees in the National Food Security Act 2013, in which subsidised food grains and meals to persons living below the poverty line including all pregnant and lactating mothers, children up to the age of six years and malnourished children. However, despite the guarantees enshrined in these two schemes, it is evident from primary research conducted, between the years 2016-2018 that Anganwadi Centres in the State of Nagaland are falling woefully behind the standards they prescribe.

Between November 2016 and October 2018, a series of fact finding missions was conducted to investigate the state of Anganwadi Centres and their compliance with the ICDS guidelines across six different districts in the State of Nagaland. It was universally found that Anganwadi Centres across the State are in a deplorable condition, with inadequate physical structures and facilities, operational services, stocks of food rations and medicines. Anganwadi Workers and Anganwadi Helpers do not have an effective grievance mechanism to address to higher authorities their concerns about the conditions of the centres and the personal expenses they incur in the course of the centres' operation, including the non-payment of their honoraria. None of the centres visited complied with the opening hours envisioned in the scheme and as a result, the provision of regular preschool activities was impossible.

Every centre suffered from severe hygiene issues, with many not providing clean toilet facilities or a clean drinking water supply. The evident lack of knowledge of AWWs and AWHs of other health benefit schemes, including the Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakaram (JSSK) reflected a core flaw in the health referral system that AWCs are supposed to serve. As a first point of contact for many community members, AWCs should be a hub for health knowledge and advice, however this ignorance has indirectly led to a denial of further benefit schemes that a vast number of individuals are

eligible for. This is direct evidence of a lack of adequate training for the very individuals on the ground implementing the scheme. Further, the supervisory role of Child Development Project Officers is both minimal and ineffective. Visits are rarely made and complaints made by AWWs and AWHs have not been acted upon, as is evident from the repeated visits made by fact-finding teams from between 2016 to 2018, which could only portray the lack of implementation and non-operation of the ICDS scheme in the State of Nagaland.

Aggrieved at the poor state of non functional status of the Anganwadi centres, the Petitioner sent a representation letter, dated 31.10.2018, detailing the aforementioned circumstances, highlighting the grievances and seeking for full implementation of the ICDS scheme in the Anganwadi Centre across the State of Nagaland. However, till date, rather than taking active response on the representation letter, a reply, dated 05.12.2018 was received from the office of the Directorate of Social Welfare through the Public Information Officer seeking two months extension for furnishing information from the district.

The Respondents have failed miserably in the implementation of Central Government social welfare initiatives including the ICDS and guarantees under the National Food Security Act in the Anganwadi Centres. The Respondents' inaction has directly resulted in inefficient or non-functionality of dozens of AWCs across the state, disadvantaging targeted beneficiaries of these programs and the individuals charged with their implementation, including AWWs and AWHs, which in return reflects the Respondents' inaction and violation of the fundamental rights enshrined under Article 21 of the Constitution of India, current provisions of national law and various International Conventions, including the Convention on the rights of the Child, to which India is signatory.

Order

The case is on-going.

Hygiene & Sanitation

India has a population of billions people out of which most of the population has no access to toilets. Most of the population who are dwelling in urban slums or rural areas still defecates in the open and have no proper access to clean and healthy sanitation provision. Slum dwellers in major metropolitan cities, reside along railway tracks, under the bridges or flyovers and have no access to toilets or a running supply of water. The situation in urban areas in terms of scale is less as compared to rural areas. However, what aggravate these problems the most in urban areas are majorly poor seerage systems and highly congested living conditions.



The dismal condition of running water for the cluster in Delhi, was found to be a major hindrance for the pregnant and lactating women in the community.

Sewerage systems, if present at all, is not maintained which often leads to overflow of raw sewage and ends up spreading diseases. Overall a million residents are residing in 20 cities including all the metropolitan cities. In these places the existing sewage systems, built to serve a population of around 3 million people, can't handle the wastewater produced by an average of 12-14 million residents. According to WHO's definition, sanitation refers to: "the provision of facilities and services for the safe disposal of human urine and faeces. Inadequate sanitation is a major cause of disease worldwide and improving sanitation is known to have a significant beneficial impact on health both in households and across communities. The word 'sanitation' also refers to *the maintenance of hygienic conditions, through services such as garbage collection and wastewater disposal.*"

With such a skewed sanitation and highly poor condition of drainage as well as sewage system, there is an immense likelihood for the locals especially that of the pregnant women and lactating mothers to encounter severe water and vector-borne diseases like Malaria, cholera, Dengue, Chikungunya etc. Looking at the space and population density, it is pertinent to observe that such communicable diseases won't take much time to spread.

In the past, government agencies have typically built sanitation infrastructure, but sanitation professionals are now concentrating on helping people to improve their own sanitation and to change their behaviour. Improved sanitation has significant impacts not only on health, but on social and economic development, particularly in developing countries. The health sector has a strong role to play in improving sanitation in developing countries through policy development and the implementation of sanitation programmes. Below mentioned are few of the significant cases which HRLN is working on.

1. Mohd. Saleem V. Delhi Urban Shelter Improvement Board and Others W.P No 10827/2016

Synopsis

This petition was filed in the High Court of Delhi to ensure the practical availability of toilets to the residents of Dhobi Ghat, Kalyanpuri, especially women. A fact-finding mission to Dhobi Ghat, Kalyanpuri found that toilets under Delhi Urban Shelter Board (DUSIB) authority had been so poorly maintained and yet also prohibitively expensive that in every instance, whether they were used or not, they fell short of constituting provision of sanitation infrastructure that DUSIB is responsible for providing. In addition, upon

interviewing 18 households it was found that Delhi Jal Board (DJB) had not provided water to around 15 households at all, and existing water connections were insufficient for residents' needs.

Facts

Dhobi Ghat, Kalyanpuri is in East Delhi. Its residents are predominantly Muslim and OBC. A fact-finding mission to Dhobi Ghat, Kalyanpuri found that toilets under Delhi Urban Shelter Board (DUSIB) authority had been so poorly maintained and yet also prohibitively expensive that in every instance, whether they were used or not, they fell short of constituting provision of sanitation infrastructure that DUSIB is responsible for providing. In addition, upon interviewing 18 households it was found that Delhi Jal Board (DJB) had not provided water to 15-18 households at all, and existing water connections existing were insufficient for residents' needs. Dhobi Ghat, Kalyanpuri has had toilets installed. Under the Delhi Urban Shelter Improvement Board Act of 2010 (DUSIB Act) provision of toilets in the slum clusters is DUSIB's responsibility (see annexures P-2 and P-3). DUSIB has appointed the Sanitation Business Society, a local NGO/civil agency, to manage usage free collections and to maintain the toilets. The caretaker charges Rs 2/- for each toilet usage. Residents have been informed that the caretaker that had been placed by the agency has left long back as he did not receive any salary from them. Under the DUSIB Act Section 11, charges for the use of toilet may be levied without notice via publication of a scheme and opportunity to be heard regarding it. However, also under Section 11, DUSIB is statutorily prohibited from levying other contributions including monetary contributions and/or labor without notice via publication of a scheme and opportunity to be heard.

Dhobi Ghat, Kalyanpuri residents do not have money to maintain the bathrooms themselves, either on an individual or collective basis. The absence of lights around the toilet facility means they can only be used during the day. The toilets are also unclean. Residents have attempted to help themselves by getting cleaning supplies when possible, but still it is not enough. The fees levied particularly impact women and children. Women continue to defecate in the open because they are unable to access the toilets at night. Children are turned away from toilets because they are unable to pay, even when they are ill, which are the reasons caused by poor sanitation in the JJC.

There are two legal problems with these fees. First, they are arbitrary. The usage fees are set at the caretaker's will according to his discretion, which is an arbitrary standard without justification, rather than an expert calculation about how much needs to be paid to keep

facilities going, opportunities to mitigate cost, and how much residents are in fact able to pay. Second, and more importantly, JJC residents are poor. Given the very premise of DUSIB toilet provision, to provide the most basic of services to those who cannot pay for them, charging persons fees to use the toilet is against the spirit and purpose of Parliament's intent. Under DUSIB, government can have no expectation without further procedures that residents have a legal obligation to fully "fix" the problems that these toilets have created; their work in trying to make a basic level of decency for themselves should not be construed to suggest that these residents could, should, or must fully maintain government-provided facilities.

Orders

20.01.2017

Ms. Mini Pushkarna, the learned Standing Counsel who appeared for DUSIB, on instructions, states that in terms of the order dated 17.08.2016 passed by this Court in W.P.(C) No.7245/2016, steps have already been initiated for providing toilet facilities in various *jhuggies jhoperi* clusters in Delhi. It is stated that the petitioner was already informed of the steps taken vide letter dated 26.09.2016. A copy of the said letter has been furnished to the learned counsel for the petitioner today.

An affidavit be filed by the respondent No.1 within two weeks from today explaining the steps stated to have been taken. Rejoinder, if any, by the petitioner within two weeks thereafter.

19.05.2017

1. This writ petition complains with regard to lack of sanitation and toilet facilities in J.J. Cluster. An affidavit has been filed by the respondent No.1 Delhi Urban Shelter Improvement Board disputing the petitioner's contentions.
2. The writ petition has been filed in public interest which purpose would be served if the respondents inform this Court with regard to the status of sanitation and toilet facilities in all the J.J. Clusters.
3. We, therefore, direct the respondent No.1 Delhi Urban Shelter Improvement Board, which is concerned with these issues to file an affidavit by an highest authority stating the following details:

- (i) Number of J.J. Clusters;
 - (ii) Population of J.J. Clusters;
 - (iii) Availability and number of toilets provided in J.J. Clusters; and
 - (iv) Availability of running water and usability in J.J. Clusters.
4. Such affidavit shall be filed within four weeks from today.
 5. We make it clear to the parties that this Court would in random inspect to verify the facts stated in the affidavit on the next date of hearing.
 6. The petitioner shall file an affidavit giving the details of the houses referred in para 14 of the writ petition.

2. Manickchand Vs SDMC& Ors. W.P No 1023/2017

Synopsis

The Present PIL was filed highlighting lack basic access to sanitation including toilets, sewage disposal, and clean water to the resident of Madanpur Khadar.

Facts

The Petitioner who is a resident of Madanpur Khadar, which is a densely populated low-income settlement, has filed this petition on behalf of all the residents in the honourable High court of Delhi. The residents lack basic access to sanitation including toilets, sewage disposal, and clean water. The responsibility to provide clean and accessible toilets falls on the South Delhi Municipal Corporation (SDMC) & Delhi Urban Shelter Board (DUSIB). Further, there is an absence of sewer lines in some areas which falls under the authority of the Delhi Jal Board (DJB).

Currently, an independent contractor operates the toilet by charging a high and arbitrary fee which is discriminatory against the low-income residents. Women and Children who are the most vulnerable are forced to defecate in the open which is not only unhygienic but also unsafe. The lack of access to such facilities is a deprivation of the Article 21 of the Indian Constitution which guarantees the right to life and personal liberty, including the right to live with dignity. Additionally, The Supreme Court has ruled that the Indian Constitution under Article 21 guarantees both water and sanitation as fundamental to life which is being deprived to the residents in Madanpur Khadar.

Orders

The High court has directed South Delhi Municipal Corporation and Delhi Jal Board to file a counter affidavit.

23.08.2017

In view of the counter affidavit of DUSIB – respondent no.2 (at page 296), response of South Delhi Municipal Corporation – respondent no.1 and Delhi Jal Board – respondent no.3 is necessary. Let respondent nos.1 and 3 file their counter affidavits within four weeks from today. Counter affidavit stands filed on behalf of the respondent No.2. 2. Let the respondent Nos.1 and 3 also file their counter affidavits within three weeks from today. 3. Rejoinders thereto, if any, be filed before the next date of hearing.

3. Nirmal Gorana Vs South Delhi Municipal Corporation and Others W.P. (C) 8891/2017

Synopsis

The Petitioner filed the petition on the behalf of the residents of Bhat Camp, Badarpur, South Delhi to ensure the practical availability of proper sanitation and clean drinking water to the slum dwellers of Bhat camp, Badarpur. who lack basic access to sanitation including, sewage disposal, clean drinking water, and free from user pay toilet. A Public Interest Litigation (PIL) has been filed in the honourable High Court of Delhi. Residents urgently require these to avoid serious bodily harm, water borne diseases and possible death from illness particularly women and children.

Facts

Bhat camp is located next to Badarpur village, in South Delhi. It is a densely populated with a population of around 2500 and mostly people living there are of low income settlement migrated from Rajasthan living there by more than 30-40 years. A fact-finding mission to Bhat camp found that sewage line under the authority of South Delhi Municipal Corporation (SDMC) had been so poorly maintained that there was blockage in the sewage line due to which during monsoon water come out and enter into the houses, logged in the narrow lanes and get mixed up with water pipelines making life difficult for the residents.

There is only one boring/ tubewell from which two connections were given for residents who managed to get water by spending their own money for pipe lines. To provide clean drinking water in JJ colonies is the duty of Delhi Jal Board (DJB) which has not taken care properly from a very long time due to which there is breakage in the pipe lines occurred at different places and breakage can be seen clearly in the pipe lines. These pipelines are further surrounded by garbage and sewage water and due to this sewage water has started getting into these pipe lines from the broken gaps hence, there is a foul smell and dirt in the water.

During monsoon period water pipelines are submerged into the drain. Due to non-availability of clean drinking water slum dwellers have to buy drinking water bottles from the vendors selling drinking water bottle which cost them for Rs. 20 per jar and in a day; they buy around 3-5 bottles in a day depending upon the size of the family and their income is very low due to which they have to spend a lot on drinking water. Some women travel long distance to get drinkable water from other places.

The water is not good even for domestic purpose and can cause serious health issues and water borne diseases to the residents. For the slum dwellers, there is one public toilet which was installed by Delhi Urban Shelter Improvement Board (DUSIB), functioning in assistance with a private contractor. As the contractor is running the toilets, they can only be used during the day. It operates between 05:00 am and 10:00/10:30 pm.

The fees levied arbitrarily particularly impact women and children. Women continue to defecate in the open because they are unable to access the toilets at night. Children are turned away from toilets because they are unable to pay, even when they are ill, which are the reasons caused by poor sanitation in the JJC. Due to the densely population in this low-income settlement, the residents have been forced to buy water from private sources which are expensive and unsustainable. Many cases of waterborne diseases have been reported due to the lack of execution of responsibility on the part of the South Delhi Municipal Corporation (SDMC) and Delhi Jal Board (DJB).

Order

10.10.2017

1. Issue notice to the respondents to show cause as to why rule nisi be not issued, returnable on 24th January, 2018.
2. Mr. Swastik Singh, learned counsel accepts notice on behalf of the respondent no.1.

3. Mr. P. Chauhan, learned counsel accepts notice on behalf of the respondent no.2.
4. The respondent nos. 1 and 2 shall conduct a spot inspection before filing the counter affidavits. Counter affidavits/status report shall be filed within six weeks from today. Rejoinder thereto, if any, be filed before the next date.
5. Subject to the petitioner taking steps, notice shall issue for the service of the respondent no. 3, returnable on 24th January, 2018. Notice issued to respondent no.3 shall indicate that a status report/counter affidavit shall be filed within five weeks of the receipt of the notice.

4. Setu Niket Vs. Union of India and Ors. W.P. (C) 5909/ 2017, C. M Appl. No. 43147/ 2018

Synopsis

The ground for urgency is that the adolescent girls in and around the areas of Samaypur Badli Industrial area and the Lal Bagh Jhuggi in Mansarovar Park, lack accessibility and availability of menstrual hygiene products and also awareness about the basic menstrual hygiene. Non availability and accessibility of sanitary napkins and consequent use of other unsanitary forms of menstrual hygiene products (like cloth) are leaving the adolescent girls and women susceptible to innumerable infections and other health hazards. There is an urgent need to provide them access to the benefits under the Menstrual Hygiene Scheme and to ensure accessibility and availability of menstrual health hygiene facilities to the adolescent girls residing in the above mentioned areas and extend to National Capital Territory of Delhi.

Findings from the fact-finding mission:

The adolescent girls did not have access to basic hygiene products and were victims of social and cultural taboos surrounding menstruation, causing them embarrassment, a fear of ostracism, resulting in them being susceptible to diseases and infections of the reproductive tract system.

Adolescents, who attended government schools, received sanitary pads from their schools initially; however the service has been discontinued for the past 9-10 months without proper intimation or the reason for such discontinuance.

The residents of the abovementioned area were poor. They found the commercially manufactured sanitary napkins high-priced and therefore unaffordable due to their socio-economic background. Trapped in such a situation with no alternatives, they are forced to use cloth and other alternatives during their menstruation.

Many of the girls were suffering from menstrual cramps, pain, rashes etc. regularly due to usage of traditional methods during their menstrual cycles for which they did not seek medical aid because there is a prevalent belief that it will attract unnecessary attention and ridicule often associated with the topic.

Order

13. 08. 2019

On 13th March 2018, on an application filed by Ms. Shaoni Mukherjee, this court had permitted her to make submissions in the writ petition without being impleaded as a party. Today, a report has been handed over in court on behalf of Ms. Shaoni Mukherjee. On examination of this report, we are of the view that Ms. Shaoni Mukherjee would be a necessary and proper party as her contribution would help to serve the cause of this writ petition. Accordingly, with the consent of the parties, we modify the order of 13th March 2018 and implead Ms. Shaoni Mukherjee as petitioner no.2. Let amended memo of parties be filed. Let the report be filed on record, after supplying a copy thereof to counsel for the opposite side. The present petition has highlighted the lack of knowledge regarding Menstruation and Menstrual Hygiene and sensitisation of the same, in adolescent girls in schools run by the Govt. of NCT of Delhi and by the Corporations. We are informed that the Delhi Government has a scheme in the name of UDAAN which was roled out on 3rd April 2019 under which adolescent girls are provided sanitary napkins by Accredited Social Health Activists (ASHAs) at a subsidised rate of Rs.6/-. Mr. Ghosh also submits that since its inception, the scheme has been availed by more than 45000 non-school going adolescent girls on regular monthly basis. The government has purchased 14.4 lakhs sanitary napkins which approximately costs Rs.28 lakhs and another supply of 9 lakhs sanitary napkin is in the pipeline which would be received in the stores between 13th to 16th August 2019. However, there is no specific information as to whether they have been received by now or not. We are also informed by Mr. Ghosh that nearly 42,700 adolescent girl have been educated during the first quarter of the current financial year 2019-2020 about the standard practice in menstrual hygiene in a healthy manner and for maintaining of personal hygiene

removing various doubts and misconceptions. Mr. Ghosh has also drawn the attention of the court to the affidavit filed by Directorate of Education wherein it has been stated that in all schools run by the Delhi Government under the Kishori Yojana, the girls have been provided with Sanitary Napkins free of cost. Although some material has been placed before us, but we find that there are no details as to the number of schools under the Delhi Government, under the New Delhi Municipal Committee and under the South, East and North Delhi Municipal Corporation. We also request the Departments to provide the break-up of number of schools which are co-educational and schools which are meant only for girls. We also direct the respondents to provide information as to whether any common circular has been issued to all the Heads of the Institutions and as to whether a Power Point Presentation or any material has been circulated so that there is uniformity in information being transmitted to the children. This we say for the reason that in case there are different programmes and there are differences in the form of education, two children who may not belong to same school, may be left confused as to the different information supplied to them. The aim and object of the schemes should be first to educate the children, remove their doubts and educate them about the reasons and the importance of their personal hygiene. While imparting this education, every effort should be made to ensure the privacy of the children. The access to the sanitary napkins should also be in such a way that a child may not get embarrassed. At least once, in two weeks, the children should be updated and interactive session should be held allowing them to interact with the teachers/counsellors so that their queries can be answered. The circulars, if not issued, should be issued within four weeks. Similarly, counsellors, if not appointed, should be appointed within four weeks. The Power Point Presentation of the common matter, which is to be shared with the student should be prepared and uniformly circulated.

Let the affidavits be filed within six weeks positively. The affidavit should also disclose the number of toilets, exclusively for girls, in co-educational institutions across the board.

A copy of this order be served on Ms. Mini Pushkarna, counsel for SDMC, to enable the South Delhi Municipal Corporation to respond and also to appear in the matter.

Lack of Essential Medicines

Research has revealed the shocking lack of access to essential medicines in India, despite thousands being approved in an attempt to generate wider availability. Researchers at Newcastle University, UK and in Mumbai, India publishing in the *Journal of Global Health*, found that policy to open up the market has generated a large number of brands of medicines, but there are still not enough available in the pharmacies. In theory, competition within India's vast market for generic drugs should ensure that essential medicines are available in private retail outlets at a price people can afford. However, the study found that despite there being multiple approved products listed in India databases, few were available in private pharmacies at a price people could afford.



Expired and undistributed medicine thrown out in the open in Narainsena PHC, Bishnupur district, Manipur

The researchers examined the drugs available for six common health needs: artemisinin (malaria), lamivudine (HIV/AIDS), rifampicin (TB control), oxytocin (reproductive health), fluoxetine (mental health) and metformin (diabetes). The study found that for each of the medicines there were multiple approved products listed in Indian databases, 2186 in total. They found that only metformin was easily available- in 91% of the pharmacies studied- followed by rifampicin which was present in just above half the pharmacies (64.5%). The other four medicines were available in less than half. In addition, the medicines were also available in fixed dose combinations (FDCs), where two or more drugs are combined in a set ratio in a single dose form, usually a tablet or capsule. There are concerns in India over the safety and effectiveness of these products. In 2007, the Indian regulatory body the Central Drugs Standard Control Organization (CDSCO) banned 294 FDCs which had been approved by state authorities but had never received central authorization; in 2012 a further 45 FDCs were withdrawn.¹

1. Union of India and Anr. Pfizer Limited and Ors Civil Appeal No. 22972 of 2017 (arising Out Of Slp (C) No.7061 Of 2017)

Synopsis

In 2016, the government had banned over 300 FDC drugs on the ground that they involve 'risk' to humans and safer alternatives were available. However, this decision was later overturned by the court. This fact was brought about as an argument by the drug companies during the Delhi High Court hearing.

On the other hand, the government contended that the FDC medicines are 'new drugs' and, therefore, would require license from Drugs Controller General of India (DGCI) for sale and manufacture. The fact that the banned drugs lacked approval was a secondary issue, and the primary focus was that they 'lacked safety and efficacy'. The government also said that it was difficult to implement any action at state level, as there were no valid licences for making any of the banned FDCs. Thus, the government believed that ban of these drugs was the only option left.

The All India Drug Network, a civil society group welcomed the decision. They mentioned that the banned FDCs account for Rs. 2500 crore, but represent only a small part of the actual amount. According to their estimate, the market for unsafe, problematic

1. <https://medicalxpress.com/news/2018-01-lack-essential-medicines-india-revealed.html>

FDCs in India is at least one-fourth of the total pharma market which is valued at Rs. 1.3 trillion.

Facts

After a long drawn fight led by health activists against pharmaceutical companies, the Union Health Ministry recently banned the manufacture, sale and distribution of 328 fixed-dose combinations (FDCs) of drugs with immediate effect. These include widely popular drugs like Saridon, and skin cream Panderm, antibiotic Lupidiclox and combination diabetes drug Gluconorm PG, among others. It also restricted another six.

The notification, issued on March 10, read “On the basis of recommendations of an expert committee, the central government is satisfied that it is necessary and expedient in public interest to regulate by way of prohibition of manufacture for sale, sale distribution for human use of said drugs in the country.”

The health ministry had been trying to ban these drugs for the past two years, on the grounds that they are ‘irrational’ and ‘unsafe’. This comes after the SC asked for the matter to be examined by the Drugs Technical Advisory Board (DTAB) in December 2017. The report of DTAB recommended the ban of the 328 FDCs, as there was no therapeutic justification for their ingredients. It also suggested restricted manufacture and sale of the six FDCs. The Supreme Court said it would look into the safety of another 15 drugs with a fresh investigation, as it could not use the DTAB report to ban them.

Order

R.F. Nariman, J.

1. Leave granted.
2. The present appeals and transfer petitions relate to the interpretation of Section 26A of the Drugs and Cosmetics Act, 1940 (hereinafter referred to as “the Drugs Act”). By the impugned judgment of the learned single Judge of the Delhi High Court dated 1.12.2016, the learned single Judge has held that the mandatory condition precedent for the exercise of the power by the Central Government under Section 26A of the Drugs Act is the prior consultation of the Drugs Technical Advisory Board (DTAB) set up under Section 5 of the said Act. It must be stated that the learned single Judge differed from judgments of the Karnataka and Madras High Courts in this regard,

wherein two other learned single Judges of two other 3 High Courts have held that such consultation with the DTAB is not mandatory before exercise of such power under Section 26A. Since we are concerned only with this narrow question that has been decided by the learned single Judge of the Delhi High Court, we are not going into any other contentions that have been raised by learned counsel for the parties.

3. The issue regarding the prevalence of many Fixed Dose Combinations (hereinafter referred to “FDCs”) that were flooding the Indian market and had not been tested for efficacy or safety was considered by the Parliamentary Standing Committee on Health and Family Welfare in its 59th Report in May, 2012. The Standing Committee observed that some of the State Licensing Authorities have issued manufacturing licenses for a very large number of FDCs without prior clearance from the Central Drugs Standard Control Organization (CDSCO). Such FDCs can pose significant risks to persons and need to be withdrawn immediately in that human lives can be at risk. The Committee recommended that a clear and transparent policy may be framed for approving FDCs based on scientific principles, and that, at present, 4 Section 26A of the Drugs Act is adequate to deal with the problem of FDCs not cleared by the CDSCO. Pursuant to the aforesaid report, the Ministry of Health in October, 2012 issued directions to States and Union Territories under Section 33P of the Drugs Act not to grant licenses to FDCs falling under the definition of “new drugs” and not approved by the Drug Controller General of India (DCG (I)). The DCG (I), in turn, had requested all States/Union Territories Drug Controllers to ask concerned manufacturers in their respective States/Union Territories to prove the safety and efficacy of such FDC licenses issued prior to 1.10.2012, without due approval of the DCG (I), within a period of 18 months, failing which such FDCs would be considered for being prohibited, both qua manufacture and marketing in the country. On 5.7.2013, the DCG (I) vide its communication to the State Drug Controllers asked manufacturers to make applications as per the procedure prescribed within this 18 month period. We have been informed that a large number of applications were received from the manufacturers within the 18 month period for 2911 products, which had to be subjected to examination.
4. With the approval of the Ministry of Health and Family Welfare, the CDSCO constituted 10 different Committees for examination of the said applications which were received on 3.2.2014. As the said Committees could examine only about 295 applications, on 16.9.2014, the Ministry of Health and Family Welfare constituted a Committee under the Chairmanship of Professor C.K. Kokate, Vice Chancellor of

KLE University, Belgaum, Karnataka for examining the safety and efficacy as per the following terms of reference:

- a. Those FDCs which are considered grossly irrational/unsafe based on pharmacokinetic and pharmacodynamic interaction, dosage compatibilities of FDCs vis-a-vis that of single ingredients present in the FDC and available literature/evidence.
- b. Those FDCs which the Committee may consider necessary for further deliberation with any of the 10 Expert Committees already constituted.
- c. Those FDCs which are considered as safe and effective based on pharmacokinetic and pharmacodynamics interaction, dosage compatibilities of FDCS vis-a-vis that of single ingredients present in the FDC, available literature/evidence, clinical experience and other data available.
- d. Those FDCs which may be considered as rational based on present data and knowledge available. However, data in post market scenario is required to be generated within a period of 1 to 2 years to confirm the same.
- e. All the FDCs falling, under category “b” above would be referred to the respective Expert Committee out of 10 Expert Committees already constituted.

Composition of Expert Committee for examining the safety & efficacy of Fixed Dose Combinations (FDCs) is as under:

Name of Expert Name & Address of Institutions Qualification on Status in the Committee

1. Prof. Chandrakant Kokate Vice-Chancellor, KLE University, Belgaum, Karnataka & Ex-President of Pharmacy Council of India. M. Pharm, Ph.D. Chairman
2. Dr. C.L. Kaul Former Director, NIPER, 432, Mahatma Society, Koth Road, Pune-38. B. Pharm, Ph.D. Member
3. Prof. Sanjay Singh Deptt. of Pharmaceutics, IIT, BHU, Varanasi. M. Pharm, Ph.D. Member
4. Dr. C.D. Tripathi Prof. & HOD (Pharmacology), Safdarjung Hospital, New MD, Pharamacology Member 7 Delhi.
5. Dr. Bikash Medhi Deptt. of Pharmacology, PGIMER, Chandigarh. MD, Pharmacology Member
6. Dr. Sanjeev Sinha Prof. (Medicine), AIIMS, New Delhi MD, Medicine Member
7. Dr. R.K. Khar Former Dean & Head, Jamia Hamdard, 403, Lalleshwari Vatika, GH-12, Sector-21D, Faridabad-1210 01.

A series of meetings were conducted by the Committee (6 meetings corresponding to 11 days) as well as by a sub-group of the Committee (2 meetings) for examination of these approx. 6320 applications.

5. The first assessment report of the aforesaid Committee was submitted to the Ministry of Health and Family Welfare on 19.1.2015 and was presented before the Ministry on 4.3.2015, wherein the Committee was requested to mention detailed reasons against each FDC considered as “irrational” by the Committee. The Committee did not discuss FDCs already approved by the DCG(I) and FDCs which were licensed pre 8 21.9.1988 i.e. before the introduction of Schedule Y to the Drugs Act. The Committee stated, “in case the Committee made any comment with respect to the above inadvertently, it shall be treated as not discussed.”
6. On 16.4.2015, a detailed report in this regard was submitted by the Kokate Committee to the Ministry stating the reasons for declaring FDCs as irrational. We have been informed that for the FDCs which were considered as irrational by the Committee, the Committee wrote to various manufacturers/associations calling upon them to submit material to establish the therapeutic justification/rationality of the FDCs. Replies received from such associations were examined by the Expert Committee and final recommendations therein were given only on 10.2.2016. In category A, following the final recommendations of the Expert Committee, the Central Government has banned 344 FDCs. In category B, 944 FDCs needed to be considered/deliberated upon further, which meant that they would be referred to the respective Expert Committees out of the 10 Expert Committees already constituted for further examination. In category C, 1493 FDCs 9 have been declared “rational” and we are informed that approvals have since been issued by the DCG(I) in respect of these FDCs. In category D, 126 FDCs have to be considered for further generation of data by the prospective applicants. It is only after carrying out of this exercise, that by notifications dated 10.3.2016 issued under Section 26A, the Central Government banned manufacture and sale of 344 FDCs.
7. In March 2016, a large number of writ petitions were filed in the Delhi High Court against the aforesaid notifications. The impugned judgment then followed on 1.12.2016 disposing of 454 petitions, followed by an order dated 21.12.2016, in which the Delhi High Court disposed of 51 further writ petitions in terms of the judgment dated 1.12.2016.
8. Letters Patent Appeals were filed before the Delhi High Court. Meanwhile, the Union

of India filed transfer petitions in this Court. This is how these matters have been heard by us in civil appeals arising out of SLPs against the judgment of the single Judge dated 1.12.2016 and in transfer cases in which the 10 LPAs pending before the Delhi High Court have been transferred to us.

9. Ms. Pinky Anand, learned Additional Solicitor General, took us through various provisions of the Drugs Act, and emphasized that Section 26A does not expressly refer to the DTAB. According to her, a large number of provisions of the Drugs Act expressly refer to the DTAB in various contexts and, therefore, it is not permissible for the Court to read a mandatory requirement of consultation with the DTAB into Section 26A, when such mandatory consultation is present in other provisions, but is conspicuous by its absence in Section 26A. She further went on to state that the provisions of Section 26A are legislative in nature, and ultimately, once the Central Government arrives at a satisfaction based on relevant materials, judicial review of the Central Government decision taken on the basis of Expert Committee reports is extremely limited. She launched an all out attack against the single Judge's judgment and stated that the Madras and Karnataka view, with which the Delhi High Court differed, is the correct view in law. Shri Colin Gonsalves, learned senior counsel, 11 supported her arguments, and appeared in civil appeal arising out of SLP(C) Nos.10170-10178 of 2017.
10. By way of reply, Shri C.S. Vaidyanathan, learned senior counsel, argued that the impugned single Judge judgment was based on an earlier Division Bench judgment in *E. Merck (India) Ltd. and another v. Union of India and another*, (2001) 90 DLT 60, which upheld the constitutional validity of Section 26A on the ground that since the DTAB had to be consulted before passing an order under Section 26A, the said Section would pass constitutional muster. He also referred us to this Court's judgment in *Systopic Laboratories (Pvt) Ltd. v. Dr. Prem Gupta & Ors.*, 1994 Supp (1) SCC 160 in furtherance of the same proposition. According to learned counsel, it is clear on a reading of Section 5 of the Drugs Act that it will apply to both the Central Government and the State Governments on all technical matters that arise out of the administration of the Drugs Act. Since Section 26A deals only with such technical matters, it is obvious that the DTAB's advice has to be taken in every such case as otherwise, if it were open to the Central Government to pick and choose in which case 12 they would take such advice and which case they would not take such advice, the provision itself would become arbitrary and unreasonable. According to the learned senior counsel, Section 5(5) of the Drugs Act is very important in that it is the DTAB alone who may constitute

sub-committees consisting of persons who are not members of the DTAB, who may consider particular matters, thereby making it clear that the DTAB alone can induct experts who are outside Section 5 and not the Central Government. He further referred to the Drugs and Cosmetics Rules, 1945 (hereinafter referred to as the “Drugs Rules”), in particular Rules 21, 68A, 122A, 122D and 122DA, to buttress his submission that a detailed filtration process has to be gone through before a drug can be manufactured and put on the market and that the Central Government cannot ban such drug without consulting the technical expert under the Drugs Act namely, the DTAB, that is set up under Section 5. He also argued that Sections 10A and 26A were introduced by way of an amendment in 1982 and this being so, it is clear that it is assumed by Parliament that Section 5 of the Drugs Act will be read along with both of them so as to make the DTAB a mandatory consultee before action is taken under Section 26A.

11. Shri Vashisht, learned senior counsel appearing for some of the respondents, adverted to Section 5 and stated that it was in two parts, the first being advice to the Central Government on all technical matters arising out of the administration of the Drugs Act and the second (and distinct part) being to carry out other functions assigned to it by the Drugs Act. It is clear, therefore, that in all matters which fall within the first part, the advice of the Board would be mandatory before the Central Government were to take action under Section 26A. He also referred us to Section 7A of the Drugs Act and argued that when the said Drugs Act expressly states that nothing in Section 5 is to apply, it is expressly so stated and that, therefore, the necessary inference would be that Section 5 would apply in all situations other than those covered by Section 7A. He further argued that Section 26A does not have a non obstante clause which puts out of harm's way Section 5, but only a “without prejudice” clause and that too restricted only to Chapter IV, making it clear that Section 26A would have to be read along with Section 5. According to him, therefore, there is no reason to interfere with the judgment of the Delhi High Court.
12. Dr. A.M. Singhvi, learned senior counsel, argued that on a cursory look at the persons who constitute the DTAB under Section 5, it is an extremely high ranking body which is the technical expert set up by the statute and, therefore, the High Court judgment is right in stating that in all cases arising under Section 26A prior consultation with the DTAB is a must. He argued, in the alternative, that on a purposive and harmonious construction of the Drugs Act as a whole, a middle approach could be that the Central Government may, in emergent situations, not consult the DTAB, but in all

other situations should give reasons why the DTAB was not consulted, otherwise the exercise under Section 26A would be found to be constitutionally infirm. According to the learned senior counsel, hearing is mandatory under the said Section and the High Court's reading in the requirement of hearing into the said Section was absolutely correct. He also referred us to judgments dealing with not only how hearing must be added 15 when it is absent, but to a judgment of this Court which stated that conditional legislation, of which Section 26A is a clear instance, would also require hearing the affected parties.

13. In answer to these submissions, the learned Additional Solicitor General, in rejoinder, went through the 1982 amendment, which introduced Section 26A, and stated that Sections 29 and 35 thereof make it clear that amendments were made in certain Sections with reference to the DTAB under Section 5 and that, therefore, the omission of any reference to the DTAB in Section 26A is deliberate. She also went on to state that Rule 66 of the Drugs Rules, which deals with cancellation of individual licenses and which requires compliance with natural justice, should be contrasted with Section 26A of the Drugs Act which, according to her, is a legislative power as opposed to an administrative power.
14. Having heard learned counsel for the parties, it is first important to set out some of the provisions of the Drugs Act. "5. The Drugs Technical Advisory Board—
 - (1) The Central Government shall, as soon as may be, constitute a Board (to be called the Drugs Technical Advisory Board) to advise the Central Government and the State Governments on technical matters arising out of the administration of this Act and to carry out the other functions assigned to it by this Act.
 - (2) The Board shall consist of the following members, namely:— (i) the Director General of Health Services, *ex officio*, who shall be Chairman; (ii) the Drugs Controller, India, *ex officio*; (iii) the Director of the Central Drugs Laboratory, Calcutta, *ex officio*; (iv) the Director of the Central Research Institute, Kasauli, *ex officio*; (v) the Director of the Indian Veterinary Research Institute, Izatnagar, *ex officio*; (vi) the President of the Medical Council of India, *ex officio*; (vii) the President of the Pharmacy Council of India, *ex officio*; (viii) the Director of the Central Drug Research Institute, Lucknow, *ex officio*; (ix) two persons to be nominated by the Central Government from among persons who are in charge of drugs control in the States; (x) one person, to be elected by the Executive Committee of the Pharmacy Council of India, from among teachers in pharmacy or pharmaceutical chemistry or

pharmacology on the staff of an Indian university or a college affiliated thereto; (xi) one person, to be elected by the Executive Committee of the Medical Council of India, from among teachers in medicine or therapeutics on the 17 staff of an Indian university or a college affiliated thereto; (xii) one person to be nominated by the Central Government from the pharmaceutical industry; (xiii) one pharmacologist to be elected by the Governing Body of the Indian Council of Medical Research; (xiv) one person to be elected by the Central Council of the Indian Medical Association; (xv) one person to be elected by the Council of the Indian Pharmaceutical Association; (xvi) two persons holding the appointment of Government Analyst under this Act, to be nominated by the Central Government.

- (3) The nominated and elected members of the Board shall hold office for three years, but shall be eligible for re-nomination and re-election: Provided that the person nominated or elected, as the case may be, under clause (ix) or clause (x) or clause (xi) or clause (xvi) of sub-section (2) shall hold office for so long as he holds the appointment of the office by virtue of which he was nominated or elected to the Board.
- (4) The Board may, subject to the previous approval of the Central Government, make bye-laws fixing a quorum and regulating its own procedure and the conduct of all business to be transacted by it.
- (5) The Board may constitute sub-committees and may appoint to such sub-committees for such periods, not exceeding three years, as it may decide, or temporarily for the consideration of particular matters, persons who are not members of the Board. 18
- (6) The functions of the Board may be exercised notwithstanding any vacancy therein.
- (7) The Central Government shall appoint a person to be Secretary of the Board and shall provide the Board with such clerical and other staff as the Central Government considers necessary.

6. The Central Drugs Laboratory—

- (1) The Central Government shall, as soon as may be, establish a Central Drugs Laboratory under the control of a Director to be appointed by the Central Government, to carry out the functions entrusted to it by this Act or any rules made under this Chapter: Provided that, if the Central Government so prescribes, the functions of the Central Drugs Laboratory in respect of any drug or class of drugs or cosmetic or class of cosmetics shall be carried out at the Central Research Institute,

Kasauli, or at any other prescribed Laboratory and the functions of the Director of the Central Drugs Laboratory in respect of such drug or class of drugs or such cosmetic or class of cosmetics shall be exercised by the Director of that Institute or of that other Laboratory, as the case may be.

- (2) the Central Government may, after consultation with the Board, make rules prescribing— (a) the functions of the Central Drugs Laboratory; ***** (d) the procedure for the submission of the said Laboratory under Chapter IV or Chapter IVA of samples of drugs or cosmetics for analysis or test, the forms of Laboratory's reports thereon and the fees payable in respect of such reports; 19 (e) such other matters as may be necessary or expedient to enable the said Laboratory to carry out its functions; (f) the matters necessary to be prescribed for the purposes of the proviso to sub-section (1).
7. The Drugs Consultative Committee.— (1) The Central Government may constitute an advisory committee to be called “the Drugs Consultative Committee” to advise the Central Government, the State Governments and the Drugs Technical Advisory Board on any matter tending to secure uniformity throughout India in the administration of this Act. (2) The Drugs Consultative Committee shall consist of two representatives of the Central Government to be nominated by that Government and one representative of each State Government to be nominated by the State Government concerned. (3) The Drugs Consultative Committee shall meet when required to do so by the Central Government and shall have power to regulate its own procedure. 7A. Sections 5 and 7 not to apply to Ayurvedic, Siddha or Unani drugs— Nothing contained in sections 5 and 7 shall apply to Ayurvedic, Siddha or Unani drugs.
8. Standards of quality.— (1) For the purposes of this Chapter, the expression “standard quality” means— (a) in relation to a drug, that the drug complies with the standard set out in the Second Schedule, and (b) in relation to a cosmetic, that the cosmetic complies with such standard as may be prescribed. 20 (2) The Central Government, after consultation with the Board and after giving by notification in the Official Gazette not less than three months' notice of its intention so to do, may by a like notification add to or otherwise amend the Second Schedule, for the purposes of this Chapter, and thereupon the Second Schedule shall be deemed to be amended accordingly. 10. Prohibition of import of certain drugs or cosmetics.— From such date as may be fixed by the Central Government by notification in the Official Gazette in this behalf, no person shall import— (a) any drug or cosmetic which is not of standard quality; (b) any

misbranded drug or misbranded or spurious cosmetic; (bb) any adulterated or spurious drug; (c) any drug or cosmetic for the import of which a license is prescribed, otherwise than under, and in accordance with, such license; (d) any patent or proprietary medicine, unless there is displayed in the prescribed manner on the label or container thereof the true formula or list of active ingredients contained in it together with the quantities thereof; (e) any drug which by means of any statement, design or device accompanying it or by any other means, purports or claims to cure or mitigate any such disease or ailment, or to have any such other effect, as may be prescribed; (e) any cosmetic containing any ingredient which may render it unsafe or harmful for use under the directions indicated or recommended; 21 (f) any drug or cosmetic the import of which is prohibited by rule made under this Chapter: Provided that nothing in this section shall apply to the import, subject to prescribed conditions, of small quantities of any drug for the purpose of examination, test or analysis or for personal use: Provided further that the Central Government may, after consultation with the Board, by notification in the Official Gazette, permit, subject to any conditions specified in the notification, the import of any drug or class of drugs not being of standard quality.

12. Power of Central Government to make rules. — (1) The Central Government may, after consultation with or on the recommendation of the Board and after previous publication by notification in the Official Gazette, make rules for the purpose of giving effect to the provisions of this Chapter: Provided that consultation with the Board may be dispensed with if the Central Government is of opinion that circumstances have arisen which render it necessary to make rules without such consultation, but in such a case the Board shall be consulted within six months of the making of the rules and the Central Government shall take into consideration any suggestions which the Board may make in relation to the amendment of the said rules.
16. Standards of quality.— (1) For the purposes of this Chapter, the expression “standard quality” means— (a) in relation to a drug, that the drug complies with the standard set out in the Second Schedule, and 22 (b) in relation to a cosmetic, that the cosmetic complies with such standard as may be prescribed. (2) The Central Government, after consultation with the Board and after giving by notification in the Official Gazette not less than three months’ notice of its intention so to do, may by a like notification add to or otherwise amend the Second Schedule for the purposes of this Chapter, and thereupon the Second Schedule shall be deemed to be amended accordingly. 18. Prohibition of manufacture and sale of certain drugs and cosmetics.— From such date

as may be fixed by the State Government by notification in the Official Gazette in this behalf, no person shall himself or by any other person on his behalf— (a) manufacture for sale or for distribution, or sell, or stock or exhibit or offer for sale, or distribute— (i) any drug which is not of a standard quality, or is misbranded, adulterated or spurious; (ii) any cosmetic which is not of a standard quality or is misbranded, adulterated or spurious; (iii) any patent or proprietary medicine, unless there is displayed in the prescribed manner on the label or container thereof the true formula or list of active ingredients contained in it together with the quantities thereof; (iv) any drug which by means of any statement, design or device accompanying it or by any other means, purports or claims to prevent, cure or mitigate any such disease or ailment, or to have any such other effect as may be prescribed;

- 23 (v) any cosmetic containing any ingredient which may render it unsafe or harmful for use under the directions indicated or recommended; and (vi) any drug or cosmetic in contravention of any of the provisions of this Chapter or any rule made thereunder; (b) sell, or stock or exhibit or offer for sale, or distribute any drug or cosmetic which has been imported or manufactured in contravention of any of the provisions of this Act or any rule made there under; (c) manufacture for sale or for distribution, or sell, or stock or exhibit or offer for sale, or distribute any drug or cosmetic, except under, and in accordance with the conditions of, a license issued for such purpose under this Chapter: Provided that nothing in this section shall apply to the manufacture, subject to prescribed conditions, of small quantities of any drug for the purpose of examination, test or analysis: Provided further that the Central Government may, after consultation with the Board, by notification in the Official Gazette, permit, subject to any conditions specified in the notification, the manufacture for sale, or for distribution, sale, stocking or exhibiting or offering for sale or distribution of any drug or class of drugs not being of standard quality.

26A. Powers of Central Government to prohibit manufacture, etc., of drug and cosmetic in public interest.— Without prejudice to any other provision contained in this Chapter, if the Central Government is satisfied, that the use of any drug or cosmetic is likely to involve any risk to human beings or animals ²⁴ or that any drug does not have the therapeutic value claimed or purported to be claimed for it or contains ingredients and in such quantity for which there is no therapeutic justification and that in the public interest it is necessary or expedient so to do, then, that Government may, by notification in the Official Gazette, regulate, restrict or prohibit the manufacture, sale

or distribution of such drug or cosmetic.

33. Power of Central Government to make rules. — (1) The Central Government may after consultation with, or on the recommendation of, the Board and after previous publication by notification in the Official Gazette, make rules for the purpose of giving effect to the provisions of this Chapter: Provided that consultation with the Board may be dispensed with if the Central Government is of opinion that circumstances have arisen which render it necessary to make rules without such consultation, but in such a case the Board shall be consulted within six months of the making of the rules and the Central Government shall take into consideration any suggestions which the Board may make in relation to the amendment of the said rules. (2) Without prejudice to the generality of the foregoing power, such rules may— (a) provide for the establishment of laboratories for testing and analyzing drugs or cosmetics; (b) prescribe the qualifications and duties of Government Analysts and the qualifications of Inspectors; (c) prescribe the methods of test or analysis to be employed in determining whether a drug or cosmetic is of standard quality; (d) prescribe, in respect of biological and organometallic compounds, the units or methods of standardization; (e) prescribe under clause (d) of section 17A the colour or colours which a drug may bear or contain for purposes of colouring; (f) prescribe under clause (d) of section 17E the colour or colours which a cosmetic may bear or contain for the purpose of colouring; (g) prescribe the forms of licenses for the manufacture for sale or for distribution, for the sale and for the distribution of drugs or any specified drug or class of drugs or of cosmetics or any specified cosmetic or class of cosmetics, the form of application for such licenses, the conditions subject to which such licenses may be issued, the authority empowered to issue the same, the qualifications of such authority and the fees payable therefore; and provide for the cancellation or suspension of such licenses in any case where any provision of this Chapter or the rules made there under is contravened or any of the conditions subject to which they are issued is not complied with; (h) prescribe the records, registers or other documents to be kept and maintained under section 18B; (i) prescribe the fees for the inspection (for the purposes of grant or renewal of licenses) of premises, wherein any drug or cosmetic is being or is proposed to be manufactured; (j) prescribe the manner in which copies are to be certified under sub-section (2A) of section 22; (k) specify the diseases or ailments which a drug may not purport or claim to prevent, cure or mitigate and such other effects which a drug may not purport or claim to have; (l) prescribe the conditions subject to which small quantities of drugs may be manufactured for the purpose of examination, test or analysis; (m) require the date of manufacture and the date of expiry of potency to be

clearly or truly stated on the label or container of any specified drug or class of drugs, and prohibit the sale, stocking or exhibition for sale, or distribution of the said drug or class of drugs after the expiry of a specified period from the date of manufacture or after the expiry of the date of potency; (i) prescribe the conditions to be observed in the packing in bottles, packages, and other containers of drugs or cosmetics, including the use of packing material which comes into direct contact with the drugs and prohibit the sale, stocking or exhibition for sale, or distribution of drugs or cosmetics packed in contravention of such conditions; (j) regulate the mode of labeling packed drugs or cosmetics, and prescribe the matters which shall or shall not be included in such labels; (k) prescribe the maximum proportion of any poisonous substance which may be added or contained in any drug, prohibit the manufacture, sale or stocking or exhibition for sale, or distribution of any drug in which that proportion is exceeded, and specify substances which shall be deemed to be poisonous for the purposes of this Chapter and the rules made there under; (l) require that the accepted scientific name of any specified drug shall be displayed in the prescribed manner on the label or wrapper of any patent or proprietary medicine containing such drug; (n) prescribe the powers and duties of Inspectors and the qualifications of the authority to which such Inspectors shall be subordinate and specify the drugs or classes of drugs or cosmetics or classes of cosmetics in relation to which and the conditions, limitations or restrictions subject to which, such powers and duties may be exercised or performed; (o) prescribe the forms of report to be given by Government Analysts, and the manner of application for test or analysis under section 26 and the fees payable therefore; (p) specify the offences against this Chapter or any rule made there under in relation to which an order of confiscation may be made under section 31; (q) provide for the exemption, conditionally or otherwise, from all or any of the provisions of this Chapter or the rules made there under, of any specified drug or class of drugs or cosmetic or class of cosmetics; and (r) sum which may be specified by the Central Government under section 32-B.

33D. Power of Central Government to prohibit manufacture, etc., of Ayurvedic, Siddha or Unani drugs in public interest.— Without prejudice to any other provision contained in this Chapter, if the Central Government is satisfied on the basis of any evidence or other material available before it that the use of any Ayurvedic, Siddha or Unani drug is likely to involve any risk to human beings or animals or that any such drug does not have the therapeutic value claimed or purported to be claimed for it and that in the public interest it is necessary or expedient so to do then, that Government may, by notification in the 28 Official Gazette, prohibit the manufacture, sale or distribution of

such drug. 33N. Power of Central Government to make rules.— (1) The Central Government may, after consultation with, or on the recommendation of, the Board and after previous publication by notification in the Official Gazette, make rules for the purpose of giving effect to the provisions of this Chapter: Provided that consultation with the Board may be dispensed with if the Central Government is of opinion that circumstances have arisen which render it necessary to make rules without such consultation, but in such a case, the Board shall be consulted within six months of the making of the rules and the Central Government shall take into consideration any suggestions which the Board may make in relation to the amendment of the said rules. (2) Without prejudice to the generality of the foregoing power, such rules may— (a) provide for the establishment of laboratories for testing and analysing Ayurvedic, Siddha or Unani drugs; (b) prescribe the qualification and duties of Government Analysts and the qualifications of Inspectors; (c) prescribe the methods of test or analysis to be employed in determining whether any Ayurvedic, Siddha or Unani drug is labelled with the true list of the ingredients which it is purported to contain; (d) specify any substance as a poisonous substance; (e) prescribe the forms of licenses for the manufacture for sale of Ayurvedic, Siddha or Unani 29 drugs, and for sale of processed Ayurvedic, Siddha or Unani drugs, the form of application for such licenses, the conditions subject to which such licenses may be issued, the authority empowered to issue the same and the fees payable therefore; and provide for the cancellation or suspension of such licenses in any case where any provision of this Chapter or rules made there under is contravened or any of the conditions subject to which they are issued is not complied with; (f) prescribe the conditions to be observed in the packing of Ayurvedic, Siddha and Unani drugs including the use of packing material which comes into direct contact with the drugs, regulate the mode of labelling packed drugs and prescribe the matters which shall or shall not be included in such labels; (g) prescribe the conditions subject to which small quantities of Ayurvedic, Siddha or Unani drugs may be manufactured for the purpose of examination, test or analysis; (g) prescribe under clause (d) of section 33EE the colour or colours which an Ayurvedic, Siddha or Unani drug may bear or contain for purposes of colouring; (a) prescribe the standards for Ayurvedic, Siddha or Unani drugs under section 33EEB; (b) prescribe the records, registers or other documents to be kept and maintained under section 33 KB; and (h) any other matter which is to be or may be prescribed under this Chapter.” 15. Having heard learned counsel for the parties, it is clear that Section 26A has been introduced by an amendment in 30 1982. A bare reading of this provision would show, firstly, that it is without prejudice to any other

provision contained in this Chapter (meaning thereby Chapter IV). This expression only means that apart from the Central Governments other powers contained in Chapter IV, Section 26A is an additional power which must be governed by its own terms. Under Section 26A, the Central Government must be “satisfied” that any drug or cosmetic is likely to involve (i) any risk to human beings or families; or (ii) that any drug does not have the therapeutic value claimed or purported to be claimed for it; or (iii) contains ingredients in such quantity for which there is no therapeutic justification. Obviously, the Central Government has to apply its mind to any or all of these three factors which has to be based upon its “satisfaction” as to the existence of any or all of these factors. The power exercised under Section 26A must further be exercised only if it is found necessary or expedient to do so in public interest. When the power is so exercised, it may regulate, restrict or prohibit manufacture, sale or distribution of any drug or cosmetic. 16. Undoubtedly, Section 26A has to be read with the rest of the Drugs Act. So read, it is clear that unlike Section 6(2), Section 8(2), proviso to Section 10, proviso to Section 12(1), Section 16(2), proviso to Section 18(2), Section 33 and Section 33N, there is no explicit requirement to consult the DTAB set up under Section 5 of the Drugs Act. The question is did the Parliament do so deliberately or is it something that the Court should read into the provision? 17. As has been stated hereinabove, Section 26A was brought in by an amendment in 1982. The amendment specifically made changes in Sections 33 and 33N in which it added the words “on the recommendation of the Board”. From this, it is clear that Parliament in the very Amendment Act which introduced Section 26A made certain changes which involved the DTAB under Section 5 of the said Act. It is clear that the additional power that is given to the Central Government under Section 26A does not refer to and, therefore, mandate any previous consultation with the DTAB. On the contrary, the Central Government may be “satisfied” on any relevant material that a drug is likely to involve any risk to human beings etc. as a result of which it is necessary in public interest to regulate, restrict or prohibit manufacture, sale or distribution thereof. So long as the Central Government’s satisfaction can be said to be based on relevant material, it is not possible to say that not having consulted the DTAB, the power exercised under the said Section would be non est. Take the case of an FDC that is banned in 50 countries of the world owing to the fact that the said FDC involved significant risk to human beings. Assuming that the Central Government is satisfied based on this fact alone, which in turn is based on expert committee reports in various nations which pointed out the deleterious effects of the said drug, can it be said that without consulting the DTAB set

up under Section 5, the exercise of the power under Section 26A to prohibit the manufacture or sale or distribution of a drug that is banned in 50 countries would be bad only because the DTAB has not been consulted? The obvious answer is no inasmuch as the Central Government's satisfaction is based upon relevant material, namely, the fact that 50 nations have banned the aforesaid drug, which in turn is based on expert committee reports taken in each of those nations. Take another example. Suppose the Central Government were to ban an FDC on the ground that, in the recent past, it has been apprised of the fact that the FDCs taken over a short period of time would lead to loss of life, which has come to the notice of the Central Government through reports from various district authorities, in let us say, a majority of districts in which the said FDC has been consumed. Could not the Central Government then base its ban order on material collected from district authorities which state that this particular drug leads to human mortality and ought, therefore, to be prohibited? The obvious answer again is yes for the reason that the Central Government has been satisfied on relevant material that it is necessary in public interest to ban such drug. Examples of this nature can be multiplied to show that the width of the power granted under Section 26A cannot be cut down by artificially cutting down the language of Section 26A.

18. We were referred to a judgment of this Court in *Systopic Laboratories (supra)* at 169. Paragraph 19 of the said judgment reads as follows:- 34 “19. Having considered the submissions made by the learned counsel for the petitioners and the learned Additional Solicitor General in this regard, we must express our inability to make an assessment about the relative merits of the various studies and reports which have been placed before us. Such an evaluation is required to be done by the Central Government while exercising its powers under Section 26-A of the Act on the basis of expert advice and the Act makes provision for obtaining such advice through the Board and the DCC.”
19. It is clear that a stray sentence in a judgment without a focused argument cannot be considered as the ratio of such a judgment. Also, on a careful reading of the second sentence in paragraph 19, it is clear that all that is stated by this Court is that, while exercising its power under Section 26A of the Drugs Act, the basis of the Central Government's decision must be “expert advice”. The sentence then goes on to add that the Drugs Act makes provision for obtaining such advice through the Board and the DCC. According to us, there was no focused argument on whether such advice is or is not mandatory before powers under Section 26A of the Drugs Act can be exercised, and merely reading a stray sentence in this judgment does not lead to such a conclusion.

Equally, the single Judge's reliance upon a Division Bench judgment contained in *E. Merck (supra)*, 35 where, in holding Section 26A to be constitutional, the Court stated: "Before the Government records its satisfaction to prohibit the manufacture, sale, distribution etc. of a particular drug, opinion of the DTAB and/or Drugs Consultative Committee is obtained." This is an equally stray sentence and what has been stated with respect to *Systopic Laboratories (supra)*, applies equally to this sentence.

20. We have now to consider certain other arguments made on behalf of the respondents. One argument was that Section 5 is in two parts and that the first part necessarily applies to all technical matters that arise out of the administration of the Drugs Act, and that; therefore, the Central Government is bound to take the advice of the DTAB in all such matters. We must first advert to the fact that the DTAB is only an advisory body. No doubt, it would be desirable for the Central Government to take its advice on technical matters arising out of the administration of the Drugs Act, but this does not lead to the conclusion that if such advice is not taken power under Section 26A cannot be exercised. Indeed, the Central Government's satisfaction may be based on a number of factors, one of which may be advice tendered to it by the DTAB under Section 5. There is no warrant to read Section 26A to constrict the wide powers granted to the Central Government by a so-called harmonious construction of the statute. Another argument made is that Section 5 makes it clear that the DTAB alone can constitute sub-committees which may have persons who are not members of the Board on them. We are afraid that this again does not lead us very far. It is clear that the reason for Section 5(5) is completely different. Sub-committees may be appointed for such periods not exceeding three years or temporarily for the consideration of particular matters. Such sub-committees may be set up in the wisdom of the DTAB for short periods of time or temporarily to consider certain matters and make reports which the DTAB may then utilize. This is a power of the DTAB which can be exercised when the DTAB deems it desirable. From this power, it cannot be inferred, as a matter of logic, that since Section 5(5) permits persons who are not members of the board to sit on sub-committees, the Central Government may not, under Section 26A, refer to any persons other than those who are board members. This argument, therefore, is also rejected.
21. Yet another argument has been made that since Section 10A and 26A were brought in together by an Amendment Act in 1982, it must, therefore, somehow be assumed that the Amendment Act necessarily included a mandatory consultation with the DTAB set up under Section 5. We have already pointed out how the very amendment Act of

1982 also amended Sections 33 and 33N by referring to the DTAB and that, therefore, it is obvious that the omission of any reference to the DTAB under Sections 10A and 26A cannot but be said to be deliberate. This argument also need not detain us further.

22. A negative argument was made stating that Section 7A of the Drugs Act makes it clear that Section 5 will not apply to Ayurvedic, Siddha or Unani drugs and that, therefore, it will apply to all other drugs. The reason for Section 7A is again something very different from what has been argued. It must first be pointed out that under Chapter IVA, which is a separate Chapter introduced by Act 13 of 1964, Ayurvedic, Siddha and 38 Unani drugs are completely separately dealt with. Indeed, Section 33A, which must be read with Section 7A, expressly provides that save as provided in this Drugs Act, nothing contained in this Chapter, i.e. Chapter IV, shall apply to Ayurvedic, Siddha or Unani drugs. Chapter IVA consists of a separate and distinct drill to be followed in the case of Ayurvedic, Siddha and Unani drugs. Under Section 33C, there is a separate technical advisory board for Ayurvedic and Unani drugs and a separate consultative committee for Ayurvedic, Siddha and Unani drugs (see Section 33D). When Section 7A says that nothing in section 5 shall apply to Ayurvedic, Siddha or Unani drugs, all that it affirms is that the DTAB set up under Section 5 will apply to all drugs except Ayurvedic, Siddha or Unani medicines. The Latin maxim “*expressio unius est exclusio alterius*” cannot apply, as has been held in *State of Karnataka v Union of India & Ors.*, (1977) 4 SCC 608 at 662, making it clear that the said maxim should be very carefully applied and when misapplied would turn out to be a “dangerous master” as opposed to a “useful servant”. This has also been held in *Assistant Collector of Central Excise, Calcutta 39 Division v. National Tobacco Co. of India Ltd.*, (1972) 2 SCC 560 at 575 as follows: “The High Court’s view was based on an application of the rule of construction that where a mode of performing a duty is laid down by law it must be performed in that mode or not at all. This rule flows from the maxim: “*Expressio unius est exclusio alterius*”. But, as was pointed out by Wills, J., in *Colguoboun v. Brooks* [(1888) 21 QBD 52, 62] this maxim “is often a valuable servant, but a dangerous master...”. The rule is subservient to the basic principle that Courts must endeavour to ascertain the legislative intent and purpose, and then adopt a rule of construction which effectuates rather than one that may defeat these. “This argument, therefore, also need not detain us.
23. It was also argued that Section 26A had no non obstante clause to keep Section 5 out of harm’s way. On our construction of Section 26A, it is clear that no such non

obstante clause was necessary in that the width of the expression “is satisfied” contained in Section 26A cannot be cut down by reference to Section 5. As has been stated by us hereinabove, the expression “without prejudice” makes it clear that Section 26A is an additional power given to the Central Government which must be exercised on its own terms.

24. An argument was made that unless the provisions of Section 5 requiring consultation with the DTAB are read into Section 26A, the said Section would be arbitrary. In our opinion, there are sufficient indicators in the Section to eschew any ground of arbitrariness. The power can only be exercised based on satisfaction of material that is relevant to form an opinion that the drug in question falls within any of the three categories outlined by the Section and that, further, it is necessary or expedient to either regulate, restrict or prohibit manufacture, sale or distribution of the said drug in public interest. Indeed, this is made explicit in Section 33 EED of the Drugs Act, wherein a similar power is given to the Central Government qua Ayurvedic, Siddha or Unani drugs, where the Section states: “... the Central Government is satisfied on the basis of any evidence or other material available before it that ...”
25. If the power under Section 26A is exercised on the basis of irrelevant material or on the basis of no material, the satisfaction itself that is contemplated by Section 26A would not be there and the exercise of the power would be struck down on this ground. Further, it is argued that the provision may be read down to make it constitutionally valid, but in so doing, words cannot be added as a matter of constitutional doctrine.
26. In *Cellular Operators Association of India and others v. Telecom Regulatory Authority of India and others*, (2016) 7 SCC 703 at 740-741, this Court held as under: “50. But it was said that the aforesaid Regulation should be read down to mean that it would apply only when the fault is that of the service provider. We are afraid that such a course is not open to us in law, for it is well settled that the doctrine of reading down would apply only when general words used in a statute or regulation can be confined in a particular manner so as not to infringe a constitutional right. This was best exemplified in one of the earliest judgments dealing with the doctrine of reading down, namely, the judgment of the Federal Court in *Hindu Women’s Rights to Property Act, 1937*, *In re [Hindu Women’s Rights to Property Act, 1937, In re, AIR 1941 FC 72]*. In that judgment, the word “property” in Section 3 of the *Hindu Women’s Rights to Property Act* was read down so as not to include agricultural land, which would be outside the Central Legislature’s powers under the *Government of India Act, 1935*. This is done because it

is presumed that the legislature did not intend to transgress constitutional limitations. While so reading down the word “property”, the Federal Court held: 42 “... If the restriction of the general words to purposes within the power of the legislature would be to leave an Act with nothing or next to nothing in it, or an Act different in kind, and not merely in degree, from an Act in which the general words were given the wider meaning, then it is plain that the Act as a whole must be held invalid, because in such circumstances it is impossible to assert with any confidence that the legislature intended the general words which it has used to be construed only in the narrower sense: Owners of SS Kalibia v. Wilson [(1910) 11 CLR 689 (Aust)], Vacuum Oil Co. Pty. Ltd. v. Queensland [(1934) 51 CLR 677 (Aust)], R. v. Commonwealth Court of Conciliation and Arbitration, ex p Whybrow & Co. [(1910) 11 CLR 1 (Aust)] and British Imperial Oil Co. Ltd. v. Federal Commr. of Taxation [(1925) 35 CLR 422 (Aust)].” 51. This judgment was followed by a Constitution Bench of this Court in DTC v. Mazdoor Congress [1991 Supp (1) SCC 600 : 1991 SCC (L&S) 1213]. In that case, a question arose as to whether a particular regulation which conferred power on an authority to terminate the services of a permanent and confirmed employee by issuing a notice terminating his services, or by making payment in lieu of such notice without assigning any reasons and without any opportunity of hearing to the employee, could be said to be violative of the appellants’ fundamental rights. Four of the learned Judges who heard the case, the Chief Justice alone dissenting on this aspect, decided that the regulation cannot be read down, and must, therefore, be held to be unconstitutional. In the lead 43 judgment on this aspect by Sawant, J., this Court stated: (SCC pp. 728-29, para 255) “255. It is thus clear that the doctrine of reading down or of recasting the statute can be applied in limited situations. It is essentially used, firstly, for saving a statute from being struck down on account of its unconstitutionality. It is an extension of the principle that when two interpretations are possible — one rendering it constitutional and the other making it unconstitutional, the former should be preferred. The unconstitutionality may spring from either the incompetence of the legislature to enact the statute or from its violation of any of the provisions of the Constitution. The second situation which summons its aid is where the provisions of the statute are vague and ambiguous and it is possible to gather the intentions of the legislature from the object of the statute, the context in which the provision occurs and the purpose for which it is made. However, when the provision is cast in a definite and unambiguous language and its intention is clear, it is not permissible either to mend or bend it even if such recasting is in accord with good reason and conscience. In such circumstances, it is not possible for

the court to remake the statute. Its only duty is to strike it down and leave it to the legislature if it so desires, to amend it. What is further, if the remaking of the statute by the courts is to lead to its distortion that course is to be scrupulously avoided. One of the situations further where the 44 doctrine can never be called into play is where the statute requires extensive additions and deletions. Not only it is no part of the court's duty to undertake such exercise, but it is beyond its jurisdiction to do so." (emphasis supplied) 52. Applying the aforesaid test to the impugned Regulation, it is clear that the language of the Regulation is definite and unambiguous — every service provider has to credit the account of the calling consumer by one rupee for every single call drop which occurs within its network. The Explanatory Memorandum to the aforesaid Regulation further makes it clear, in Para 19 thereof, that the Authority has come to the conclusion that call drops are instances of deficiency in service delivery on the part of the service provider. It is thus unambiguously clear that the impugned Regulation is based on the fact that the service provider is alone at fault and must pay for that fault. In these circumstances, to read a proviso into the Regulation that it will not apply to consumers who are at fault themselves is not to restrict general words to a particular meaning, but to add something to the provision which does not exist, which would be nothing short of the court itself legislating. For this reason, it is not possible to accept the learned Attorney General's contention that the impugned Regulation be read down in the manner suggested by him."

27. Also, as a matter of statutory interpretation, words can only be added if the literal interpretation of the Section leads to an absurd result. As has been stated by us, the construction of 45 Section 26A on a literal reading thereof does not lead to any such result. Dr. Singhvi's argument to read in words to save Section 26A must, therefore, be rejected.
28. We may also mention that the Madras High Court in its judgment in *Macleods Pharmaceuticals Limited v. Union of India & Ors.*, Writ Petition Nos.21933 and 25442 of 2011, specifically held as under: "38. Thus, the Act gives in every Chapter, an indication of the functions to be exercised by the DTAB. In other words, the territory within which the DTAB is to operate and exercise its functions, is clearly demarcated in various provisions of the Act such as 5(1), 6(2), 7(1), 8(2), second proviso to Section 10, 12(1) and 33(1). But Section 26-A is completely silent about any consultation with DTAB. It is so even with Section 26-B. 39. While the advisory role of DTAB is indicated in broad and general terms in Section 5(1), it is indicated in specific terms in Sections

6(2), 7(1), 8(2), second proviso to Section 10, 12(1) and 33(1). Therefore, the absence of any reference to such requirement of consultation in Section 26-A assumes great significance. It is a well settled principle of interpretation of statutes that the Courts are not expected to supply the omission. The Parliament had consciously incorporated the expressions “after consultation with the Board” or “on the recommendation of the Board”, in certain provisions of the Act such as Sections 5(1), 6(2), 7(1), 8(2), second proviso to Section 10, 12(1) and 33(1). But it has deliberately omitted to include any 46 of those expressions while inserting Sections 26-A and 26-B. It is a case of casus omisus. Therefore, the argument that the Central Government ought to have taken the consultation of the DTAB before issuing the ban order, can hold good only if I can supply into Section 26-A, what was deliberately left out by the Parliament. This cannot be done by me and hence the first contention has to be rejected.”

29. To similar effect is the judgment of a single Judge of the Karnataka High Court in *Lundbeck India Pvt. Ltd. v Union of India*, (2014) 5 Kant LJ 440.
30. We approve of these two judgments as having laid down the correct law on the construction of Section 26A of the Drugs Act.
31. Though arguments have been made as to whether Section 26A is legislative in nature and therefore excludes natural justice, we do not propose to go into the same inasmuch as since the learned single Judge’s judgment is being set aside on one point and one point alone. In this view of the matter, we are of the opinion that the impugned judgment dated 1.12.2016 deserves to be set aside. 47
32. On the facts of these cases, a suggested course of action was stated by learned counsel appearing on behalf of the petitioners/appellants. This course is that instead of now remitting the matter back to the Delhi High Court for an adjudication on the other points raised in the writ petitions, the case of 344 FDCs that have been banned, plus another 5 FDCs that have been banned, which comes to 349 FDCs, (barring 15 FDCs that are pre 1988 and 17 FDCs which have DCG(I) approval) pursuant to the Kokate Committee report, by notifications of the Central Government under Section 26A of the Drugs Act, should be sent to the DTAB, constituted under Section 5 of the Drugs Act, so that it can examine each of these cases and ultimately send a report to the Central Government. We reiterate that only on the peculiar facts of these cases, we think that such a course commends itself to us, which would obviate further litigation and finally set at rest all other contentions raised by the petitioners. We say so because we find that the Kokate Committee did deliberate on the 344 FDCs plus 5 FDCs and

did come to a conclusion that the aforesaid FDCs be banned, but we are not clear as to what exactly the 48 reasons for such conclusions are, and whether it was necessary in the public interest to take the extreme step of prohibiting such FDCs, instead of restricting or regulating their manufacture and supply. In order that an analysis be made in greater depth, we, therefore, feel that these cases should go to the DTAB and/or a Sub-Committee formed by the DTAB for the purpose of having a relook into these cases. It is important, however, that the DTAB/Sub-Committee appointed for this purpose will not only hear the petitioners/appellants before us, but that they also hear submissions from the All India Drugs Action Network. The DTAB/Sub-Committee set up for this purpose will deliberate on the parameters set out in Section 26A of the Drugs Act, as follows.

33. First and foremost in each case, the DTAB/Sub-Committee appointed by it must satisfy itself that the use of the Fixed Dose Combinations (FDC) in question is likely to involve any one of the aforesaid three things: (a) that they are likely to involve any risk to human beings or animals; or 49 (b) that the said FDCs do not have the therapeutic value claimed or purported to be claimed for them; or (c) that such FDCs contain ingredients and in such quantity for which there is no therapeutic justification.
34. The DTAB/Sub-Committee must also apply its mind as to whether it is then necessary or expedient, in the larger public interest, to regulate, restrict or prohibit the manufacture, sale or distribution of such FDCs. In short, the DTAB/Sub-Committee must clearly indicate in its report: (1) as to why, according to it, any one of the three factors indicated above is attracted; (2) post such satisfaction, that in the larger public interest, it is necessary or expedient to (i) regulate, (ii) restrict, or (iii) prohibit the manufacture, sale or distribution of such FDCs.
35. The DTAB/Sub-Committee must also indicate in its report as to why, in case it prohibits a particular FDC, restriction or regulation is not sufficient to control the manufacture and use of the FDC. We request the DTAB/Sub-Committee to be set up for this purpose to afford the necessary hearing to all 50 concerned, and thereafter submit a consolidated report, insofar as these FDCs are concerned, to the Central Government within a period of six months from the date on which this judgment is received by the DTAB. We may also indicate that the Central Government, thereafter, must have due regard to the report of the DTAB and to any other relevant information, and ultimately apply its mind to the parameters contained in Section 26A of the Drugs Act and, accordingly, either maintain the notifications already issued, or modify/substitute them or withdraw them.

36. With these directions given on the peculiar facts and circumstances of these cases, the appeals are disposed of.
37. Insofar as the drugs that have been banned and which were manufactured pre 21st September, 1988, a list of 15 such drugs has been given to us by Mr. Kapil Sibal, learned senior counsel for the respondents. We set aside the Central Government notifications banning them as these cases were never meant to be referred to the Kokate Committee. It will be open, however, for the Central Government, if it so chooses, de 51 novo, to carry out an inquiry as to whether such drugs should be the subject matter of a notification under Section 26A of the Drugs Act.
38. Insofar as the list of 17 cases handed over by Shri Sibal, in which DCG (I) approvals have allegedly been granted, we are of the view that since the Parliamentary Standing Committee itself refers to DCG(I) approvals and the manner in which they were granted, we do not accede to Mr. Sibal's request that these 17 cases be kept outside the purview of the fresh look that has to be given by the DTAB/Sub-Committee in these cases.
39. Insofar as the status quo, obtaining as on today, is concerned, that will continue in all cases (including the 5 FDCs which are not the subject matter of stay orders already made) until the Central Government issues fresh notifications in this behalf. MADRAS CASES (TRANSFERRED CASES) T.C.(C)Nos. 308-317_of 2017 @ T.P.(C) Nos.2108-2117 of 2017 52 40. Mr. Gopal Subramaniam, learned senior counsel appearing on behalf of the original petitioners in these cases, stated that these cases have been transferred to this Court from the Madras High Court. A Section 33 ban, which was imposed on 294 FDCs in these cases, has been stayed by the Madras High Court, and the very exercise that we have proposed in the Delhi cases has apparently been carried out in this group of cases. A report of the expert committee of the DTAB to review the rationality and safety of 294 FDCs is taken on record. The report indicates that 42 FDCs reportedly were repeated or duplicate; 44 were already prohibited for manufacture in the country; 83 were considered rational; 56 were considered not rational; 49 required further generation of data; 17 were considered inadequate so far as rationality, safety and efficacy is concerned; and 3 other cases were sent for further examination by an expert committee constituted by the Ministry of Health and Family Welfare. The DTAB after review of the report and deliberations recommended that the FDC Ofloxacin and Prednisolone at serial number 75 under the category of GI in Annexure C does not appear to be rational 53 and should be re-examined. The

lists of the drugs mentioned in Annexure D are required to be prohibited/ withdrawn from the market as these are not rational. Considering that an expert body has already deliberated upon and decided these cases, we accept the report, and accordingly dispose of these petitions in accordance therewith.

2. ALL INDIA DRUG NETWORK (AIDAN) V. UOI & ORS. W.P.(C) 8555/2018 & CM APPL. 32864/2018, 34112/2018

Synopsis

The immediate trigger for the order seems to have been its purported misuse in the agriculture and dairy industry where cattle are injected with Oxytocin, to make them release milk. Petitioners, while not denying the importance of concerns regarding misuse of oxytocin in milch animals, aver the concerns of access to the drug for safe delivery in pregnant women must not be compromised under any circumstances.

LIST OF EVENTS

DATE	EVENT
29.6.2009	The 40th meeting of the Drugs Consultative Committee (DCC) notes the issue of misuse of oxytocin in dairy and agriculture by the Drugs Controller, Delhi. The DCC agrees that misuse has been reported in many parts of the country and strong vigilance is required to stop its clandestine manufacture.
20.7.2012	The 44th meeting of the DCC considers the issue of misuse of oxytocin injection in agriculture and dairy. It notes that the misuse of the drug is through clandestine manufacture and sale and opines that the diversion of bulk drug to illegal channels could be curtailed by ensuring it is sold to licensed manufacturers only.
12.11.2013	The 46th meeting of the DCC considers the issue of misuse of oxytocin prompted by the letter that Smt. Maneka Gandhi, MP, Lok Sabha has written to the Secretary, Ministry of Health and Family Welfare alleging harmful effects of misuse of oxytocin on the health of cows and buffaloes and consumers. The DCC observes that illicit manufacture of oxytocin used in extracting milk from milch animals is a clandestine activity and recommends strong measures to restrict supply of oxytocin for veterinary use and to curtail diversion of bulk drug to illegal channels.

25.11.2013	The 65th meeting of the DTAB agrees that oxytocin has definite use for therapeutic purposes and need not to be prohibited. It agrees that manufactures of bulk drug should supply active pharmaceutical drug only to licensed manufacturers for formulations and that formulations for veterinary use be sold to veterinary hospitals only. It recommends the curbing of misuse through increased surveillance and raids conducted on possible hideouts of clandestine manufacture and sale, and strict action against offenders.
17.1.2014	G.S.R. 29 (E) is notified directing that manufacturers of bulk oxytocin shall supply the active pharmaceutical drug only to manufacturers licensed under the Drugs and Cosmetic Rules, 1945 for manufacture of formulations and that formulations meant for veterinary use shall be sold to veterinary hospitals only.
1.4.2014	<p>The 67th meeting of the DTAB notes that Smt. Maneka Gandhi has one again written to the Secretary, Ministry of Health and Family Welfare regarding misuse in milch animals and its adverse affects. The DTAB observes that misuse can only be contained through enhanced surveillance by regulatory authorizes followed by stringent action against violators. The need for campaigns to sensitize the public and to enlist local police to book cases under Prevention of Cruelty to Animals Act, 1960 and Drugs and Cosmetics Act, 1940, is noted.</p> <p>The DTAB recommends addition of a clause to the issued notification related to maintenance of records of sale by retail chemists to maintain legitimate supply of the drug and also curb the misuse through legitimate sale channels.</p>
22.10.14	Circular (File No. BD/VET.CELL/10.2014) is issued by the Drugs Controller General India (DCGI) to all state drug controllers requesting details of manufacturers of bulk and formulations of oxytocin in States along with statistical information on seizures conducted, quantity seized along with its value, persons arrested, prosecutions filed, samples taken, reports of sub-standard quality received during the last three years.
22.4.2015	The 69th meeting of the DTAB considers the proposal to restrict or prohibit oxytocin because of misuse by dairy owners and defers it to the next DTAB meeting feeling that it required detailed examination with more experts.
18.8.2015	The 70th meeting of the DTAB is informed by the testimony of the experts and agrees that the drug legitimately manufactured is required for medical purposes and cannot be prohibited, and that misuse of the drug in crude form can be curbed through constant surveillance by regulatory authorities.

16.10.2015	<p>The 49th meeting of the DCC is addressed by Smt. Maneka Gandhi, Hon'ble Minister for Women and Child Development who highlights the negative consequences of misuse of oxytocin for milking cattle, the clandestine import, smuggling and manufacture of the drug and emphasized continuous surveillance and raids to deter illegal activity.</p> <p>The DCC observes the problem was related to manufacture and sale through clandestine channels rather than sale through licensed outlets. The DCC makes several recommendations to fight the misuse.</p>
28.1.2016	<p>Judgment of the Punjab-Haryana High Court in M/S Narang Medical Store vs Union of India and Ors (CWP No. 7135 of 2014) upheld the validity of the notification G.S.R. 29 (E) issued under Section 26A of the Drugs and Cosmetics Act, 1940.</p>
15.3.2016	<p>Judgment of the High Court of Himachal Pradesh in CWPIL 16 of 2014 passes several directions on the issue of illegal use of oxytocin on mulching animals and in fruits and vegetables including “(ix) Respondent No. 1 is further directed to consider the feasibility of restricting the manufacture of Oxytocin only in public sector companies and also restricting and limiting the manufacture of Oxytocin by companies whom licenses have already been granted.”</p>
30.3.2017	<p>Letter from the DCGI to all state drug controllers regarding strict regulatory control over oxytocin to curb its misuse. The letters informs that the Secretary, MOHFW held a meeting on 14th March 2017 to restrict and regulate manufacturing of oxytocin and permit its manufacturing in PSU. State drug controllers are requested, inter alia, to conduct inspections of units manufacturing oxytocin and take action as directed.</p>
22.9.2017	<p>Letter is sent from the DCGI to all state drug controllers (File No X-11026/119/2017-BD). The letter provides directions, based on a letter received from the Ministry of Health and Family Welfare dated 9th May 2017 (F. No BD/VET/CELL/13.2014(Pt-1), for various measures are to be taken to comply with the directions of the Hon'ble Himachal Pradesh High Court.</p>
12.2.2018	<p>The 78th Meeting of the DTAB agree to a) prohibit the import of oxytocin and its formulations for human as well as animal use under Section 10A of the Drugs and Cosmetics Act, 1940, b) a draft notification for regulating, restricting oxytocin formulations for human use to be supplied only to registered hospitals and clinics in public and private sector and c) to the proposal to amend rule 96 of the Drugs and Cosmetics Rules, 1945 to implement a barcoding system for oxytocin formulations to ensure track and traceability to avoid misuse.</p>

16.2.2018	Notice (File No X11026/40/2018-BD) of a meeting of CDSCO with manufacturers of oxytocin formulations on 22 nd February 2018 to discuss “appropriate measures to prevent the misuse of oxytocin” is sent by the DCGI to all manufacturers of oxytocin formulation for human and animal use.
5.4.2018	Notice (File No. 394/165/2015-Cus(AS)) is issued by Central Board of Excise & Customs (Anti-Smuggling Unit) addressed to all Principal Chief Commissioners/Chief Commissioners of Customs/Customs (Preventive), All Principal Chief Commissioners/Chief Commissioners of Customs & CGST, Director General Directorate of Revenue Intelligence and Director General Directorate of GST Intelligence. It is informed that “in a meeting held in the Prime Minister’s Office regarding the ‘Harmful effects of Oxytocin’, it has been decided that all bonafide requirements of Oxytocin would be met by indigenous production and accordingly all the imports of Oxytocin/API in any name should be banned with immediate effect.” It provides directions tightening of enforcement and vigilance to prevent smuggling of Oxytocin into India.
9.4.2018	The 53 rd meeting of the DCC agreed with the recommendations of the 78 th DTAB to tackle misuse of oxytocin. The DCC mentioned the recommendations on prohibition of import of Oxytocin, regulation of supply of oxytocin formulations for human use to only registered hospitals and clinics, adopting barcoding for track and traceability. However, it incorrectly notes that the DTAB recommended “restriction of manufacture of oxytocin formulation only to Public Sector Units to avoid its misuse”, which was not decided by the DTAB.
18.4.2018	G.S.R. 381 (E) is notified to seek public comment on Draft Rules under the Drugs and Cosmetics (Amendment) Rules, 2018 to facilitate tracking and tracing of drug formulations of oxytocin.
24.4.2018	G.S.R. 390 (E) is notified to prohibit the import of “Oxytocin and its formulations in any name of manner”, in exercise of powers under Section 10A of the Drugs and Cosmetics Act, 1940
27.4.2018	G.S.R. 411 (E) is notified in supersession of G.S.R. 29 (E) dated 17th January 2014. Through this notification, the Central Government lays down directions for the sale and distribution of oxytocin in exercise of powers under Section 26A of the Drugs and Cosmetics Act, 1940. It, inter alia, restricts the manufacture of oxytocin formulations for domestic use to public sector undertakings, prohibits sale through retail chemists and directs that the public sector undertakings shall supply the formulations directly to registered hospitals and clinics in public and private sector or specified Government entities.
27.4.2018	Press Information Bureau press release regarding the regulation of manufacture, sale and import of oxytocin in India.

21.5.2018	Office Memorandum (File No. X-11026/103/2018-BD): “Special operations to prevent and detect illegal manufacturing of (API, formulations) and import of Oxytocin in India- Regarding” issued by the DCGI to zonal/subzonal office/all port offices of CDSCO and all state drug controllers mentioning G.S.R. 390 (E) and G.S.R. 411 (E) and providing directions to conduct special operations to prevent and detect illegal manufacturing, sale and distribution of oxytocin.
27.6.2018	Press Information Bureau press release informing that the Ministry of Health and Family Welfare has restricted manufacture of Oxytocin formulations for domestic use to KAPL and the ban would come into effect from 1 st July 2018.
27.6.2018	Public Notice regarding Oxytocin Formulations is published in English mainstream newspaper.
29.6.2018	G.S.R. 620 (E) is notified to change the date that G.S.R. 411 (E) will come into force, from 1st July 2018 to 1st September 2018.
16.7.2018	Karnataka Antibiotics and Pharmaceuticals Ltd. (KAPL) sends email response to Dr. K V Babu, a medical doctor from Kerala informing him that KAPL started manufacturing of Oxytocin injection on 2 nd July 2018 and it will be made available in the month of August 2018.
25.7.2018	Under agenda item No. S-5, The 80th meeting of the DTAB agrees to amend G.S.R. 411 (E) to allow the continued sale and distribution of oxytocin by licensees under the Drugs and Cosmetics Act, 1940 and Drugs and Cosmetics Rules, 1945 to ensure availability for human use by deletion of clause No. (v) and (vii) of G.S.R. 411 (E).
08.2018	Notice (File No. 18-06/2018-DC) issued by the DCGI withdrawing the agenda no. S-5 of the 80th DTAB held on 25th July 2018 because DTAB members were not prepared for the deliberations and deleting the same from the minutes. The link to the minutes of the 80th DTAB was removed from the CDSCO website.
1.8.2018	Notice regarding oxytocin issued by the Department of Health and Family Welfare.
2.8.2018	Office Memorandum: “String regulatory actions to prevent illegal manufacturing, sale and distribution and import of Oxytocin in India- regarding” (File No. X-11026/103/2018-BD) issued by the DCGI addressed to All Zonal Offices/ sub zonal offices of CDSCO, all state/UT drug controllers and all port offices of CDSCO informing that “the issue is being discussed and monitored at highest level of Government from time to time for proper implementation of various measures taken to prevent misuse of the drug in the Country” and providing various directions for keeping strict vigil on the manufacture, sale and distribution of oxytocin.

3.8.2018	Public Notice regarding Oxytocin Formulations is published in English mainstream newspaper informing of restrictions on the manufacture of oxytocin to the public sector from 1 st September 2018.
6.8.2018	Press Information Bureau release “Health Ministry holds video conference with States to discuss issues related to regulation of oxytocin drug” provides information about a video conference of the Health Ministry with States/Uts on the status of preparedness of State Governments for implementing the amended rules for manufacture, distribution and sale.
	Hence this Writ Petition

Prayer

In view of the above facts and circumstances, and because of the life-impacting nature of the drug Oxytocin which if not available even for a day or two, can cause maternal deaths during delivery, it is most humbly prayed before this Hon'ble Court:

- 1) For a writ quashing GSR 411 (E) dated April 27, 2018 (at Annexure 1) and GSR 390 (E) dated April 24, 2018 (at Annexure 2) of the Union of India.
- 2) For an order directing the Union of India to take measures to ensure uninterrupted availability of good quality Oxytocin with cold chain at all delivery points throughout India.
- 3) For an order directing the strict implementation of requirements for sale and distribution of Oxytocin as per its Schedule H status namely sale only on doctor's prescription.
- 4) For strictures against the Ministry of Health and the Government of India for taking arbitrary decisions bearing on life and death without thinking the decision through and especially without consideration as to the impact on the maternal health in the country and without due consultation of stake holders and specifically women's health groups specially in vulnerable areas with high Maternal Mortality, consumer groups and expert obstetricians and gynaecologists, and members of the nursing profession especially midwives.
- 5) For an order directing the Union of India to appoint an expert committee of dairy technologists and scientists to find ways and means of protecting cattle and related milk output from misuse of Oxytocin, without compromising on the right to life of women in intrapartum and postpartum stages.

- 6) For an order directing investment in public education about importance of lives of women, priority that needs to be given to accessibility, affordability and availability of quality, rational, essential drugs for maternal health and to counter disinformation and false information on Oxytocin and such life-saving drugs.

Order

India is one of the country's with the highest rates of maternal mortality in the world. "Oxytocin" is used to induce labour in pregnant women and stall postpartum bleeding which is a leading grounds of maternal deaths. The drug is strongly recommended by the WHO as the choice pharmaceutical, injected at the time of human childbirth. National List of Essential Medicines (NLEM) 2011 and 2015 as well as WHO Model List of Essential Medicines includes "Oxytocin".

In this case, the Health Ministry displaying their concerns claimed that "Oxytocin" drug was misused to enhance milk production in cattle, misuse of the growth booster among trafficked children, injected to accelerate puberty among girls. They further added that "Oxytocin" will not be available at retail private chemist stores and that private pharmaceutical companies will have to stop manufacturing the drug. It proposed the restrictions on imports and decided to confine manufacturing to Karnataka Antibiotics and Pharmaceuticals Ltd, a government company.

However, domestic drug firms have been resisting the move to regulate the life saving drug. Manufacturers say availability will be severely hit if the government allows only one manufacturer to make it.

Thus, petitioners forwarded public interest petition under Article 226 of the Constitution of India seeking a writ of mandamus or any other writ, order or direction to the respondents to quash the notifications of the Union of India restraining the import, manufacture, sale and distribution of Oxytocin.

The bench noted that it is both unreasonable and arbitrary. The Union of India did not adequately weigh in the danger to the users of Oxytocin, nor consider the lethal effect to the mass generally and women particularly, of possible restricted supply if manufacture is confined to one unit. It was held by Delhi High Court that there was no scientific basis, and deficient data to maintain the conclusion that the existing availability of the drug or manner of distribution posed a peril to human life .

The Delhi High Court after taking into account the considerations furnished the order disposing off the case (14.12.2018) which allowed the writ petition to quash the ban on sale of "Oxytocin".

Various Facets of Sexual Reproductive Health & Rights for us to Consider

CLAIMING DIGNITY: AN INTRODUCTION

Dr. Mira Shiva

Claiming Dignity, is a reminder of the various rights enshrined in the Conventions to which we are signatories, the Constitution of India, the various Policies, and Acts that are supposed to protect women's reproductive rights, health rights and human rights.

The chapters reflect the anguish and frustration of those millions of women who are denied their rights and whose rights have been systematically violated. It documents the many legal cases which have resulted in passing of legal orders in favour of protecting these rights. These need to be known by those engaged with reproductive health, reproductive rights issues and gender concerns in social and health fields and legal fields.

Right to Education Right of children to Free and Compulsory Education Act 2009) is a justiciable right enacted in April 2010. It makes 8 year schooling (1 to 8th class) Compulsory for Children between 6 and 14 years. Education is a well known, accepted determinant of health. The relationship of Female literacy to Maternal and Child Health, Morbidity and Mortality is well documented. Not merely the no.4 Goal of the SDGs (Sustainable Development Goals) is Education, with its targets which aim to "Ensure inclusive and equitable, quality education and promote life long learning opportunities for all". It is also enshrined in the International Covenants World Declaration on Education for all, a Dakar Framework for Action, Universal Declaration on Human Rights and Convention on the Rights of the Child etc.

It is a sad reality that world's largest number of illiterate population and children out of school is in India. Yet the Education Budget has not been adequate. Even if there is a very marginal increase, the requirement of the recommended norm is 6%.

The large number of Out of School children, are the children of the marginalized, displaced, deprivation victims, girl children and children of minority communities, Schedule Caste, Schedule Tribes and other Backward communities.

The causes of school dropout are also well known, from poverty problems of children of migrant families, to girls dropping out because of lack of separate toilets for girls, safety security concerns on the way to school, their need for caring for younger siblings, in absence of child care crèche facilities when mothers need to go for work.

Ramakant Rai reminds us of the unimplemented Kothari Committee Recommendations and the Education Policy itself, where the poor and the marginalized are concerned, as their right to education inspite of the policy, continue to be denied.

There is an amnesia about the very concept and importance of 'school health programs' and the importance of investing in the health and education of our children, in recognizing the important gains that are possible for the children, their families, and for the nation with the Demographic Dividend that we have if we invest in our children.

The section on housing Rights poignantly describes the impact that the demolition of slums conducted without any notice, the repeated demolitions, the forced displacements have on the children and their families. What does the loss of all records and the proof of stay, mean to the poor, when they lose all entitlements, health care, education, livelihoods and are treated as 'illegal'.

As rural economy collapses with agrarian crises, drought, floods, climate chaos further contributing to it, the urban migration will only increase. As public spaces shrink and the land costs spiral, the living and working conditions of those living in overcrowded, non regularized slums will need to be addressed in planning and development process to be inclusive while, recognizing the various rights of the children facing multiple vulnerabilities and the extent of the denial of their rights.

Chinu Srinivasan clearly defines the various Reproductive health related conditions from Contraception to RTIs, STIs, maternal conditions, Toxemias of pregnancy eclampsia pre-Eclamptic toxemias, puerperal sepsis, ante partum, post partum, hemorrhage, APH & PPH etc. The essential medicines needed, presence of which should be ensure the peer. For ensuring that the Reproductive Health Rights are met several medical procedure such as

Caesarian Sections, Hysterectomies, sterilization, MTP (Medical Termination of Pregnancy) and safe abortions are also required. One third of the maternal deaths are related to abortion and comprehensive abortion care has obviously been denied for various reasons.

The non availability of these essential reproductive health services, their denial or grossly overcharging for them, providing poor quality services resulting in complications, are obvious denial of Rights. The deaths of women following sterilization in Bilaspur. Ironically, no one was found to be responsible even though Standard Treatment Guidelines were grossly violated and the laparoscope used was not sterilized. Earlier deaths of women following.

The list of Essential Medicines required for, Maternal Health, Reproductive health are listed in detail. These medicines are essential and needed for saving lives. Child birth in the biggest hospital in Jodhpur are reminders of what women face.

Denial on lack of medical facilities, doctors, medical equipment, essential medicines, anesthesia, hygienic conditions which are needed for conducting safe child birth, safe abortion, safe gynecological examination, contraception, requiring IUCD (Intra Uterine Contraceptive Device) or sterilization cannot and should not be treated as normal and acceptable as it involves women who may be poor, out of sight and out of mind for many. These continued violations of their reproductive rights are unacceptable and a matter of shame for all of us.

Dr. Rajesh Sagar and Dr. Ananya Mahapatra, have dealt with Mental Health Issues and Reproductive Rights. There has been a general lack of understanding of Mental Health issues, more so of mental health issues involving women.

Issues of Child Marriage, Intimate partner violence, issues of sexual coercion have been dealt with highlighting the mental health implications of these on the victims. These mental health implications are several, from acute and chronic depression, anxiety, emotional social anguish.

Severe mental pressure put on the women by their husbands, in laws, relatives and society to produce a male child and also not to produce a girl child and the blaming her for failing to do so, even when it is a known scientific fact that XY chromosome comes from the male partner is a shame. Pregnant women are forced to undertake illegal sex determination tests, and undergo abortion if the foetus is a female or face threat of being be, thrown out of the house by the in laws, forced to undergo multiple pregnancies till a boy is born, face taunts, psychological oppression in face of her “failure” to do so. It is a cruelty that continues inspite of the PCPNDT Act. The fear, frustration, helplessness, and hopelessness of mothers of girl children in many homes in society, which is deeply entrenched in patriarchal value system

needs to be recognized and addressed. The rights of the mother are obviously being denied and this denial is being treated as normal, which it is definitely not.

Dr. Sagar & Dr. Ananya point out that ‘the health implications of sexual coercions are psychological not physical’. “The Long term clinical problems include hyper vigilance, anxiety and phobias, somatic complaints and dissociative disorders, depression, substance abuse, suicide attempts and risk of re-victimization”.

The physical and mental health impact of coerced sterilization and forced sterilization have been addressed. Psychological & Physical violence that many women face during pregnancy has been recorded in the studies done. Much more needs to be done in this area.

The issues of law, ethics morality eugenic philosophy, potential for misuse of medical technology, physical and mental health implications for the mother are all interlinked and need to be understood, more so the human rights of the mother.

The chapter on “Breastfeeding Right, privilege or an issue of choice” by Radha Holla (highlight the various Conventions and Covenants Beijing platform for action, Program of Action of International Conference on Population and Development) She makes a strong statement that “all women work”, for wages and without wages. Unpaid caring work being a significant one that is systematically discounted. The pressure for women engaged in formal as well as informal work, juggling between productive and reproductive work is immense. Caring work includes caring of children, elders, families and the sick and in rural areas the animal too. The energy deficit created between energy consumption in the physical work double and triple burden of women and the energy nutritional intake reflects in the malnutrition status low BMI (Body Mass Index) less than 18.5 which means chronic Hunger. 42.2% of Pre pregnant women are underweight and anaemic. Women resort to cutting on sleep and much needed rest to finish the never ending work in rural communities, urban slums.

In 80’s several organizations and groups campaigned for ‘Mothers Right to work and Workers Right to Motherhood’. Radha highlight the fact that “Breastfeeding is a Biological function and part of Maternity and should not be projected as a matter of individual mother’s “choice” and “privilege”. “Women’s right to breastfeed needs to be recognized with the onus of creating circumstances for mothers to do so is on the State”.

Maternity Protection and International Code of Marketing of Breastmilk Substitutes 1981 are two International instruments to address this. The Infant Milk Substitutes, Feeding Bottles & Infant Foods, (Regulation of Production, Supply & Distribution) Act of 1992 (further amended in 2003 further strengthening it) was brought into existence

following a decade of campaigning by Baby Food and health activists. The need of the regulation was strongly felt after witnessing the aggressive promotion and marketing of the commercial artificial milk powders as breast milk substitutes, using maternity homes, medical profession to push these products by creating doubts in the minds of young mothers about their capacity to breastfeed.

Radha deals with Women's Right to Maternity Protection giving details of the various Maternity benefit Acts (1961) the entitlements under Maternity Benefit Schemes. Majority of women workers are in non formal sector and not protected by the Maternity Benefit Schemes. Even those who are in the formal sector are denied their entitlements because of their lack of awareness of their entitlements, and mothers are not assured of job protection and non discrimination.

The significance of breastfeeding to Maternal & Child Health is well recognized. In scientific medical literature it requires the women's right to breastfeed, be recognized as a fundamental right. International Labour Organisations (ILO)'s Maternity Protection convention (MPC), Convention of Elimination of Discrimination Against women (CEDAW) & UN Convention on Rights of the Child 1989 (CRC) recognize this.

WHO, UNICEF have recommended initiation within one hour Breastfeeding for 6 months for the health and protection of the baby and the mother. The extension of paid Maternity Leave from 12 weeks to 24 weeks in the Maternity Benefit Act amendment 2017 is keeping this in mind so that mother's right to breastfeed and care of new born are protected.

Radha deals with the various cases of violation of IMS Act by Baby Food Companies like Nestle who look at babies as a market of their commercial baby food.

Child marriage, coercive sterilization, Disrespect and abuse in Maternal Health care have been pervasive violations of rights of girls and women by the SRTCIDT (Convention against TCIDT Torture and Cruel, Inhuman, Degrading Treatment), has called on states to "effectively monitor & regulate practices by public and private actors in health care & educational settings to ensure the eradication of prohibited practices including inter-alia the denial of maternal health care".

"ESCR's Committees General Comment 22 clarifies "the lack of emergency obstetric care services often leads to maternal mortality and morbidity which in turn constitutes a violation of the right to life or security and in certain circumstances can amount to torture or cruel, inhuman or degrading treatments".

“In 2007 CEDAW Committee ruled that Brazil’s lack of services violated Article 12 which guarantees access to pregnancy related health services by failing to meet the specific and destensive health needs and interests of women. The committee affirmed that the state must ensure respect for the right to health in private as well as public institution”.

“The CEDAW Committee decisions established that Governments have a human rights obligations to guarantee that all women in their countries – regardless of income or racial background - have access to timely non discriminatory and appropriate maternal health services. Even when Governments outsource health services to private institutions, they remain directly responsible for their actions, and have a duty to regulate and monitor said institutions’.

This has special significance for our Indian situation where public health care facilities and services are being outsourced to private players where high costs, make essential medical care services inaccessible, unaffordable and unavailable.

Ensuring presence of essential medicines, their timely and rational use eg. Oxytocis & Misoprostal could save lives of thousands of women suffering from Post Partum haemorrhage. The fact that a large number of the pregnant women are anaemic and some severely anaemic, and any bleeding can prove fatal for them. Chances of survival of the new born baby following the death of the mother become extremely slim. The sufferers are also the other children, who are deprived of mother’s care and nurturing which reflects in their nutritional status, health, psychological development.

Timely use of Emergency Contraceptive within 48 hours could prevent a victim of sexual violence from getting pregnant with the child of the rapist. It is really a human tragedy when such victims are denied abortion because of the delay involved in seeking medical help by when the abortion is considered “illegal” as MTP is allowed upto 20 weeks of pregnancy. Repeated denials to such victims inflicted pregnancies is unfortunate, more unfortunate is the absence of timely medical, psychological counseling, timely medical examination and provision of emergency contraceptive within 48 hours of the Act.

Justice J S Verma Report had recommended Gender Sensitive “One stop centres”, with adequate budget allocation and trained personnel.

Gender sensitive quality, contraceptive services, abortion services (with abortion being decriminalized) maternal health services, adequately equipped with essential diagnostic and therapeutic facilities and medicines provided and used rationally are needed.

Claiming Dignity is recommended reading for those who feel committed to contribute

to changing the existing scenario, for millions of women, who are being denied their rights. In a socio political context, when patriarchal mindsets do not even understand and acknowledge existence of these rights, working for fulfilling these rights becomes all the more important. Claiming Dignity is for reminding those making policies, programs and schemes for women; those allocating finances & budgets for women's health programs; those implementing these policies about these various rights. Highlighting the various violations, demanding accountability and using every tool constitutionally available, to ensure that reproductive & health rights of women are fulfilled and this is done so without the women having to beg or grovel, but are fulfilled with the dignity that they deserve, as these are their rights.

ARTICLE 1

Breastfeeding: Right, Privilege or An Issue of Choice

Ms. Radha Holla

At the Eleventh International Conference of the International Coordinating Committee of National Institutions for the Promotion and Protection of Human Rights, the Amman Declaration and Programme of Action was adopted, which pledged to

Promote the realization of the human rights of women and girls, including as found in CEDAW, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, and other human rights norms and standards, into national law and policies¹; and

Monitor the activities of businesses, from local to global, and report on any adverse impacts on women's and girls' enjoyment of their human rights².

The Programme of Action further seeks to Protect and promote reproductive rights without any discrimination, recognizing reproductive rights include the right to the highest attainable standard of sexual and reproductive health, the right of all to decide freely and responsibly the number, spacing and timing of their children, and on matters related to their sexuality, and to have the information and means to do so free from discrimination, violence or coercion, as laid out in the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development³.

1. Pt. 7, *Amman Declaration*. https://www.outrightinternational.org/sites/default/files/Amman_Declaration.pdf

2. Pt. 15, *Amman Declaration*. https://www.outrightinternational.org/sites/default/files/Amman_Declaration.pdf

3. Programme of Action, *Amman Declaration*. https://www.outrightinternational.org/sites/default/files/Amman_Declaration.pdf

This chapter looks at two aspects of reproductive rights. Section 1, Women's Right to Maternity Protection examines the status of maternity protection in the country, with a special focus on women working in the unorganized sector and home makers. Section 2, Women's Right to Unbiased Information analyses the role of the infant milks and baby food industry.

Background

All women work. They work in the formal and in the informal economy. They work for wages and also without wages. Their unpaid work, which includes almost all reproductive work of care has, till recently, not been considered as work. As an increasing number of women in the child-bearing years enter the job-market, they have to carefully balance their work-life, juggle between their productive and reproductive roles, which have to be played simultaneously, to ensure that they take the best care of themselves, their children and their families within their limited time constraints. The responsibilities in each of the spheres often ignore the demands and constraints of the other sphere, and thus further deepen women's secondary status both in the home and in the labour market.

In poor households, the overwhelming domestic work invariably translates into chronic anemia and malnutrition, especially in situations where women's low social status means that they eat last and least. According to one estimate, 42.2% of pre-pregnant women are underweight, which is about seven percentage points higher than the average fraction underweight among women 15–49 y old⁴. During pregnancy and lactation, malnutrition worsens as the nutritional needs of the foetus and the infant are also met by the woman. Inadequate nutrition and heavy work is often accompanied by cultural taboos on food during pregnancy and lactation, which also contributes to some extent towards intensifying the problem of malnutrition and anemia.

Malnutrition contributes to increased morbidity of both the mother and the child⁵; besides not gaining adequate weight during pregnancy, malnutrition can result in anaemia and lowered immunity, difficult and prolonged labour and low birthweight baby. Anaemia is a leading cause of maternal mortality. New agricultural technologies, international trade in commodities and food including aggressive advertising have resulted often in the disappearance or devaluation of several cheap and freely available indigenous foods that could improve women's nutritional status at little cost.

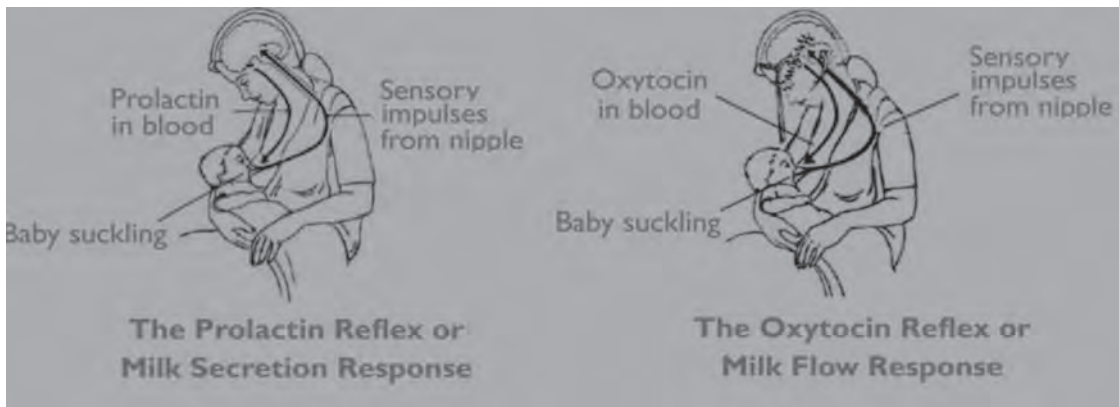
4. Diane Coffey. Prepregnancy body mass and weight gain during pregnancy in India and sub-Saharan Africa. PNAS. March 17, 2015. Vol. 112 No. 11. 3302-3307.

5. Evidence on the consequences of maternal morbidity. Available at <http://www.ncbi.nlm.nih.gov/books/NBK225432/>. Accessed on 13th April 2016.

Breastfeeding is the natural way of feeding infants. It benefits both the infant and the mother, the former by being the perfect food and immunological agent needed for healthy growth, and the latter by lowering the risk of getting breast and ovarian cancers. However, the gendered world that women live in poses several challenges to optimal breastfeeding.

Successful breastfeeding is dependent upon two hormones produced by the mother – prolactin and oxytocin (Fig. 1).

Fig. 1 – How breastfeeding happens



Source: Infant and Young child feeding Counselling: A training course: The 3 in 1 course, Participant's Manual, Breastfeeding Promotion Network of India

Prolactin, which is triggered by suckling of the breast, results in milk production. This milk is stored in the breast. Oxytocin is needed to help the milk produced to flow from the breast to the baby's mouth. This hormone is controlled by the mother's state of mind. Anxiety, stress and loss of confidence hinder the release of oxytocin, and prevent the flow of milk from the breast to the baby's mouth, often leading to problems such as painful breasts, abscess and mastitis. In such situations, mothers often resort to artificial feeding. As this reduces suckling at the breast, less milk is produced, and over time, this can lead to cessation of breastfeeding. Over decades, the infant formula manufacturers have sown doubts in women that their bodies cannot produce enough milk to meet the nutritional needs of their children, and this doubt is the beginning of the vicious cycle of less suckling by the infant and increased stress of the mother, that ends with formula feeding.

Is breastfeeding a matter of choice?

To breastfeed or not is often projected as a "choice" of the woman. This is not true.

Breastfeeding is a part of the continuum of the role of the mother's body in feeding the child – through the placenta at the foetal stage, and through breastmilk after birth. The bodies of almost all pregnant women produce milk after birth, making it clear that lactation itself is not a matter of choice. Thus breastfeeding is not a choice, but rather a right of the woman, though the woman may choose NOT to breastfeed.

The notion of breastfeeding choice, rather than respecting breastfeeding as a right, frames breastfeeding as a consumerist and lifestyle choice. As the Feminist Breeder notes:

When a biological function is viewed as a “choice” being made by an individual, society easily decides that it has no vested interest in supporting that “choice”. If society has no vested interest in supporting that choice, then it's no wonder a Judge recently ruled that employers can fire breastfeeding mothers. The judge thinks it was the mother's “choice” and the company was not obligated to support it.

Treating it as a “choice” turns a right into a privilege that discriminates against the majority of women. Only those women with enough time, support, skilled assistance and unbiased information can successfully breastfeed. Working women who then are often forced into not breastfeeding are either castigated for making a “bad” choice or commiserated with; but there is little effort made to ensure system changes that will enable her to breastfeed, as no one is held particularly accountable for lack of support. Recognizing the woman's right to breastfeed, on the other hand, puts the onus of creating the circumstances in which she can successfully breastfeed on the State and thus makes the right justiciable.

There are two international instruments that address these issues and that fall within the framework of Reproductive Rights. The first is Maternity Protection and the second is the International Code of Marketing of Breastmilk Substitute (hereinafter referred to as the Code). Recognizing the pernicious impact of the aggressive marketing of infant milksand foods that displace breastfeeding, the Indian Parliament legislated the Code as the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act in 1992, and further amended it in 2003 to strengthen it. The Act restricts the aggressive marketing of infant milksand foods for children under two years of age, including promotion of such products directly to caregivers and to the health system by any means.

Women's right to maternity protection

Maternity rights accrue to the woman independently of the child, though, on the other, child rights cannot be adequately realized without ensuring women's human rights.

Maternity rights seek to

- Ensure partial compensation for wage loss so that the woman is not compelled to work till the last stage of pregnancy, and can take adequate rest before and after delivery;
- Ensure appropriate practices, care and service utilization during pregnancy, safe delivery and lactation;
- Support women to follow optimal breastfeeding practices including carrying out exclusive breastfeeding for the first six months of the infant's life.
- Maternity entitlements emerge from the fundamental human right of maternity protection. Entitlements require government action either in the form of creating and enforcing legislation, or provision of services or both.

International instruments

Acknowledging the multiple roles that women play, especially their reproductive role, and the obligations of society to offer social services to women, the Universal Declaration of Human Rights and the International Convention on Economic, Cultural and Social Rights have recognized maternity protection as a fundamental human right. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) has proclaimed the provision of maternity protection and childcare as essential rights that will allow women to combine family responsibilities with work and participation in public life. Besides the Preamble, Art. 4 of CEDAW makes a special note that maternity protection measures “shall not be considered discriminatory”.

Maternity protection Convention 183 of International Labour Organization (ILO), which covers all employed women, including those in atypical forms of dependent work, lays out the components⁶:

- A minimum of 14 weeks of maternity leave, including six weeks of compulsory post-natal leave;
- Cash benefits during leave of at least two-thirds of previous or insured earnings provided from social insurance or public funds; adequate cash benefits out of social assistance funds for women who do not meet qualifying conditions.

6. ILO. Maternity protection at work: a key human right to prevent maternal mortality and morbidity. Available at http://www.google.co.in/url?sa=t&rct=j&q=&esrc=s&source=web&cd=9&cad=rja&uact=8&ved=0CEsQFjAI&url=http%3A%2F%2Fwww.ohchr.org%2FDocuments%2FIssues%2FWomen%2FWRGS%2FMaternalMortality%2FILO.doc&ei=ejkuVcPzLMunsgH8yoCgCg&usg=AFQjCNFpJlF4a6T7pmXHdM-uliRwQZejRQ&sig2=R3HLll_jy1c8oxW18WBrlQ&cbvm=bv.90790515,d.bGg

- Access to medical care, including pre-natal, childbirth and post-natal care, as well as hospitalization when necessary;
- Health protection: the right of pregnant or nursing women not to perform work prejudicial to their health or that of their child;
- Employment protection and non-discrimination during pregnancy, whilst on maternity leave or whilst nursing.
- Breastfeeding: minimum of one daily break, with pay.

ILO Recommendation 191 extends the entitlements, and specially mentions the provision of breastfeeding facilities. For instance, a recommendation on maternity leave seeks to extend the period of paid leave to 18 weeks. Item 6 on Health Protection introduces the idea of risk assessments of and elimination of risk at the places where pregnant or lactating women work, paid leave if transfer to a safer place of work is not possible, detailed definitions of arduous and hazardous work, and so on. Item 10 extends the scope of maternity protection to adoptive parents.

International instruments dealing with child rights also make direct and indirect references to maternity protection. The Convention on the Rights of the Child has put the onus on the State to “ensure the development of institutions, facilities and services for the care of children” and make them available to all children. The Innocenti Declaration of 1990 set the creation of legislation for maternity protection as a specific target; in 2005, the Declaration reiterated this demand. The Global Strategy for Infant and Young Child Feeding made a specific demand to enact legislation that extended maternity protection to women in the informal economy, specifying that women in paid employment should be provided with paid maternity leave, part-time work arrangements, on-site crèches, facilities for expressing and storing breastmilk and breastfeeding breaks.

Maternity protection, especially the provision of paid breastfeeding breaks, addresses the problems of breastfeeding to some extent, by allowing working women to either suckle the baby or use breast pumps at regular intervals so that the breasts continue to produce milk. Breastfeeding and childcare facilities at the work place help in ensuring the mother’s peace of mind that the baby is being looked after. However, neither intervention tackles the problem of lack of self-confidence.

Status of maternity protection in India

Article 39 (e) and Article 42 of the Directive Principles of State Policy explicitly recognize maternity relief and adequate protection of pregnant and lactating women. In the *Bandhua Mukti Morcha v Union of India* case, the Supreme Court held that

It is the fundamental right of every one in this Country, assured under the interpretation given to Article 21 by this Court in Francis Mullen's case, to live with human dignity, free from exploitation. This right to live with human dignity, enshrined in Article 21 derives its life breath from the Directive Principles of state policy and particularly clauses (e) and (f) of Article 39 and Article 41 and 42 and at the least, therefore, it must include protection of the health and strength of workers men and women, and of the tender age of children against abuse, opportunities and facilities for children to develop in healthy manner and in conditions of freedom and dignity, educational facilities, just and humane conditions of work and maternity relief. These are the minimum requirements which must exist in order to enable a person to live with human dignity and no State neither the Central Government nor any state government has the right to take any action which will deprive a person of the enjoyment of these basic essentials.⁷

Though there are several Acts that provide for maternity entitlements such as the Employees State Insurance Act, 1948, the Factories Act, 1948, the Plantations Labour Act, 1951, and the Maternity Benefit Act, 1961, this section will only examine the last Act in the context of such entitlements of women working in the formal sector.

The Maternity Benefit Act, 1961, hereinafter referred to as MBA, entitles maternity benefits to women working in the organized sector⁸, who form a miniscule percentage of the total population of women in the country. It extends to the whole of India and covers every factory, plantation, mine and shop or establishment that employs 10 persons on any day in the preceding 12 months. Women who have worked 80 days in the 12 months preceding delivery are entitled to the benefits under the Act⁹.

Since its enactment, amendments and case law have broadened the scope of the Act. Despite this, MBA is one of the laws that is least implemented in the country.

7. 1984 AIR 802, 1984 SCR (2)67

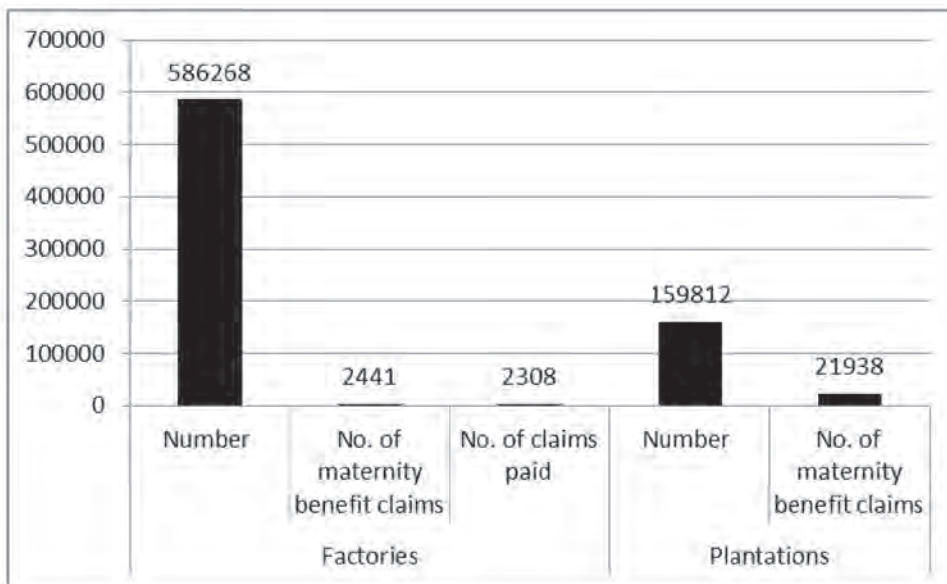
8. Sec. 2 of the Maternity Benefit Act, 1961: Application of Act. -- (1) It applies in the first instance, to every establishment being a factory, mine or plantation [including any such establishment belonging to Government and to every establishment wherein persons are employed for the exhibition of equestrian, acrobatic and other performances]:

(2) [Save as otherwise provided in [sections 5A and 5B] nothing contained in this Act] shall apply to any factory or other establishment to which the provisions of the Employees' State Insurance Act, 1948 (84 of 1948), apply for the time being.

9. However, the Act does not apply to any such factory/other establishment to which the provisions of the Employees' State Insurance Act are applicable for the time being. But, where the factory/establishment is governed under the Employees' State Insurance Act, and the woman employee is not qualified to claim maternity benefit under section 50 of that Act, because her wages exceed Rs. 3,000 p.m. (or the amount so specified u/s 2(9) of the ESI Act), or for any other reason, then such woman employee is entitled to claim maternity benefit under this Act till she becomes qualified to claim maternity benefit under the E.S.I. Act.

Data from the Labour Bureau¹⁰ shows that of the 73,35,483 working factories in India less than 10% implement MBA. The statistics further reveal the abysmal state of maternity protection (Fig. 2).

Fig. 2: Maternity benefit claims in factories and plantations (2012)



Source: Labour Bureau, 2013

Paid maternity leave/wage compensation

MBA stipulates that the maximum period for which any woman shall be entitled to paid maternity leave is 12 weeks in all whether taken before or after childbirth. There is neither a wage ceiling for coverage under the Act nor there is any restriction as regards the type of work a woman is engaged in, provided that she will not work in any establishment during this period. Women who have undergone miscarriage or abortion and adoptive mothers are also entitled to paid maternity leave for the same period.

In terms of the length of paid maternity leave, the situation in India is extremely discriminatory. For instance, government employees and those working for public sector undertakings are entitled to 24 weeks of maternity leave, while for those employed in the

10. Pocket Book of Labour Statistics 2013. Labour Bureau. Ministry of Labour and Employment. Available at www.labourbureau.nic.in/PBLS_2013.pdf

private sector it is just 12 weeks, though currently, the Labour Ministry is seeking to amend the law to increase the leave to 24 weeks for the first two children, with 12 weeks leave for the third child. Twelve weeks of maternity leave is being considered for adoptive and commissioning mothers. In the meantime, amendments and case law have extended the scope of maternity leave.

Prior to the amendment of 1989, a woman employee could not avail of the six weeks' leave preceding the date of her delivery; she was entitled to only six weeks leave following the day of her delivery. However, according to the amendment, in case a woman employee does not avail of six weeks' leave preceding the date of her delivery, she can avail of that leave following her delivery, provided the total leave period, i.e. Preceding and following the day of her delivery does not exceed 12 weeks¹¹.

In *Municipal Corporation of Delhi v. Female Workers (Muster Roll)*, Supreme Court AIR 2000 SC 1274 the Court upheld the claims of the female daily wage workers employed by the Municipal Corporation of Delhi (MCD) to maternity leave and other benefits in accordance with MBA, regardless of whether they were employed under formal contracts or not. The Court held that the provisions of the Act entitle maternity leave even to women engaged on casual basis or on muster roll basis on daily wages and not only those in regular employment are wholly in consonance with the Directive Principles of State Policy in Art. 19, 42, and 43 of the Constitution of India. The relevant law cited in the judgment included, besides MBA itself, Art. 14 (right to equal protection) and 21 (right to a dignified life) of the Constitution; *Hindustan Antibiotics Ltd. V. Workmen*, 1967 AIR 948 (holding that Article 14 requires the government to treat all labour sectors alike) and CEDAW Article 11 (States Parties should protect women's labour rights, including by providing maternity leave).

High Courts of Madras (*K. Kalaiselvi vs. Chennai Port Trust*), Kerala (*P. Geetha vs. The Kerala Livestock Department*), Delhi (*Rama Pandey vs. Union of India & Ors*) and Bombay (*Dr. Mrs. Hema Vijay Menon vs. State of Maharashtra*) have extended the right to paid maternity leave and child care leave to surrogate mothers.

In the case of *Seema Gupta vs. Guru Nanak Institute of Management*, 135 (2006) DLT 404, the petitioner had, on rejoining duty, sought one year's extended maternity leave on account of her "erratic and indifferent health condition as well as that of her infant child"; her services were instead terminated on grounds of unauthorized leave/absence within two months of extended maternity leave. Rule 43 (4)(b) - enables the employer to grant, and

11. The qualifying period of 80 days does not apply to a woman who has immigrated into the State of Assam and was pregnant at the time of immigration.

the employee to seek up to one year's leave in continuation of the initial maternity leave. As the Rule does not require the employee to give a medical certificate, it clearly implies that medical concerns alone are not determinative in granting such extended leave. Holding that "The present case, and application of Rule 43, falls into what may be justly described as a "horizontal" application of the fundamental right, viz Article 15(3) in order to give effect to Article 42", the Delhi High Court stated that Impugned termination letter was illegal and directed the institution to reinstate the petitioner to her post.

Wage compensation in the unorganized sector and for home makers

Maternity rights being fundamental rights, should logically be universal. However, the battle to extend adequate and non-discriminatory entitlements to women working in the unorganized sector and to home makers is still nowhere near being won. Though the Unorganized Workers Social Security Act, 2006 covers women in the unorganized sector, it requires that the government formulate a scheme to provide maternity benefits, which has yet to be done.

The Right to Food as a Right to Life was recognized in the People's Union of Civil Liberties v. Union of India case, and thus the foundation was laid for the inclusion of the National Maternity Benefit Scheme (NMBS), 1955, which provided pregnant and lactating women belonging to the Below Poverty Line category with a conditional maternity entitlement of Rs.500/- to ensure nutrition and care¹².

The NMBS is one of the two centrally-sponsored welfare schemes providing maternity benefits; the other is the Indira Gandhi Matritva Sahayog Yojana (IGMSY), which conditionally entitles all women to maternity benefits of Rs. 6000. The conditions include the age of the mother, the number of children, the number of antenatal visits to the health centre and exclusive breastfeeding. IGMSY is currently being applied in 52 districts on a pilot basis. In addition, some states have their own schemes (Table 1)

12. Nikita Aggarwal and Sejal Dand. *Towards a universalist conception of adequate maternity entitlements*. In forthcoming publication of ECCD Alliance

Table 1: Some Maternity Benefit Schemes

Name of Scheme	State/Central	Amount	Objectives	Conditionalities
Indira Gandhi Matritva Sahyog Yojana (IGMSY)	Centrally sponsored	Rs. 6000 as partial wage compensation to be given in two installments between the third trimester and till the child attains the age of 6 months subject to fulfillment of maternal and child health conditions. The first installment of Rs 3000 is to be released during the third trimester once pregnancy is registered at AWC / health centre within four months of pregnancy. The second installment is released 6 months after delivery provided health conditionalities are met.	<p>Promoting appropriate practices, care and service utilization during pregnancy, safe delivery and lactation.</p> <p>Encouraging women to follow (optimal) Infant and Young Child Feeding (IYCF) practices including early and exclusive breastfeeding for the first six months.</p> <p>Contributing to better enabling environment by providing cash incentives for improved health and nutrition to pregnant and lactating women.</p>	<p>The benefit is restricted to pregnant women for upto the first two live births provided they are of 19 years of age and above.</p> <p>The woman or her husband does not work in Government / Public Sector Undertaking (Central and State)</p> <p>At least two Antenatal check-up with Iron Folic Acid tablets and TT injection to be completed.</p> <p>The health conditions to be fulfilled are</p> <p>The birth of the child should have been registered</p> <p>The child should have received BCG, DPT I, II and III doses and three OPV doses</p> <p>The mother should have attended atleast three growth monitoring and IYCF counselling and</p> <p>Exclusive breast feeding for six months and introduction of complementary feeding as certified by the mother.</p>

<p>Dr. Muthulakshmi Reddy Maternity Benefit Scheme</p>	<p>Tamil Nadu</p>	<p>Rs. 12,000 in 3 installments provided conditionalities are met with. The first will be in the 7th month of pregnancy, the second immediately after delivery and the last after completion of the infant's immunization as per the time schedule</p>	<p><i>Providing cash assistance to poor pregnant women to ensure access to nutritious food</i></p> <p><i>Compensating wage loss during pregnancy</i></p>	<p><i>The pregnant mother should be of age 19 years and above.</i></p> <p><i>The pregnant woman should be in the Below Poverty Line (BPL) group</i></p> <p><i>Beneficiary should have minimum 3 AN visits at concerned PHC</i></p> <p>Beneficiary should have availed</p> <p>TT immunization</p> <p>Blood grouping and typing</p> <p>Hb% level Measurement</p> <p>Weight Measurement</p> <p>Blood Pressure Recording</p> <p>One Obstetrics Ultrasonogram done)</p> <p>Testing for HIV at the time of early AN registration</p> <p>Every visit Weight, B.P. ,HB status should be checked</p> <p>Delivery should be in Govt. Institutions (PHC,GH, Govt. MEDICAL COLLEGE HOSPITALS.</p> <p>Completion of third dose of DPT/ Hepatitis - B and Polio / Pentavalent vaccine for the child as per the time schedule.</p>
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Mamata	Odisha	Rs. 5000 in 2 installments the first at six months of pregnancy and the 2 nd on the completion of immunization	<p>To provide partial wage compensation for pregnant and nursing mothers so that they are able to rest adequately during their pregnancy and after delivery.</p> <p>To increase utilization of maternal and child health services, especially antenatal care, postnatal care and immunization.</p> <p>To improve mother and child care practices especially exclusive breastfeeding and complementary feeding of infants.</p>	<p>Pregnant and lactating women must be 19 years of age and above</p> <p>For the first 2 live births</p> <p>Must not be in Govt. And / Public Sector Undertakings (Central and State) employees or be spouse of such employee</p> <p>Has to register herself at the Anganawadi Centre (AWC) / Mini AWC/health centre to which she belongs, have at least one ANC visit, get IFA, receive at least one TT vaccination and one ANC counselling</p> <p>Has to register birth</p> <p>Have child weighed at least twice</p> <p>Attend at least two IYCF counseling sessions</p> <p>Complete BCG, Polio 1&2, DPT&2</p>
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<p>Meghalaya Maternity Benefit Scheme</p>	<p>Meghalaya</p>	<p>Rs. 4000 in two equal installments the first for antenatal component and second after delivery & stay of 48 hours for post delivery treatment</p>	<p>REDUCE OVERALL MATERNAL MORTALITY & INFANT MORTALITY TO INCREASE INSTITUTIONAL DELIVERY INTEGRATE FINANCIAL/ CASH ASSISTANCE WITH ANC DURING PREGNANCY PERIOD INSTITUTIONAL CARE DURING DELIVERY & IMMEDIATE POSTPARTUM PERIOD IN THE HEALTH CENTER REDUCE ANEMIA & HAEMORRHAGE IN PREGNANT WOMAN.</p>	<p>THE PREGNANT MOTHER SHOULD NOT BE LESS THAN 19 YEARS OF AGE. SHOULD BE A BPL OR FAMILY INCOME FROM ALL SOURCES SHOULD NOT EXCEED MORE THAN RS. 1 LAKH PER ANNUM . THE PREGNANT MOTHER SHOULD COMPLETE AT-LEAST 3 ANC WITH TT INJECTION & IFA TABLETS. THE SCHEME IS LIMITED ONLY UP TO 2 LIVE BIRTHS, I.E ONLY FOR THE 1ST & 2ND CHILD THE SCHEME IS LIMITED ONLY TO INSTITUTIONAL DELIVERIES AND NOT HOME DELIVERIES, I.E. IN GOVERNMENT HOSPITALS & ACCREDITED PRIVATE HOSPITALS. EACH BENEFICIARY REGISTERED UNDER THIS SCHEME SHOULD HAVE A MMBS CARD ALONG WITH A M&CP CARD.</p>
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A common shortcoming of all the schemes is the presence of conditionalities that are discriminatory. For instance, one of the conditions is that the pregnant or lactating woman should not be under the age of 18. However, given the reality of early marriage and the fact that the adolescent pregnant girl is at higher risk of maternity-related complications and having a low-birthweight baby, her need for nutrition, health care and support from the state is greater; the age conditionality denies her these very essential services. The conditionality of the two-child norm discriminates against the majority of women have no agency and whose repeated pregnancies have weakened them. It also violates the child's right to adequate nutrition by creating obstacles to breastfeeding.

Paternity leave

A father's right to paid paternity leave is increasingly being recognized globally as essential to furthering gender equality. Currently, no law provides for paternity leave in India. However, the Central Government, in 1999, by notification under Central Civil Services (Leave) Rule 551 (A) made provisions for paternity leave for a male Central Government employee (including an apprentice and probationer) with less than two surviving children for a period of 15 days to take care of his wife and new born child. The leave must be availed 15 days before or within 6 months from the date of delivery of child, or else it shall be treated as lapsed. For paternity leave the employee shall be paid leave salary equal to the pay last drawn immediately before proceeding on leave. Also, the same rule applies when a child is adopted.

While the private sector is left free not to provide paid paternity leave, case law entitles male teachers in private schools to have the same benefits including paid paternity leave as those working in government schools (Chander Mohan Jain vs. N.K. Bagrodia Public School & Ors¹³).

Health protection at the workplace

Health protection at the workplace is the right of all workers. During pregnancy and the period of lactation, the special biological needs of their bodies and their babies demand certain gender-specific interventions at the workplace including rest and adequate maternity leave. As the 1999 WHO Statement 1999 made during the drafting of C 183 noted:

Working women who has given birth needs rest and recuperation at least four months but more because of health consequences if they return to work earlier. They will suffer recurring uterine prolapse, UTI/urinary tract infection, anemia, fatigue, malnutrition, etc.

The special interventions related to maternity include protection from hazardous work as well as reduced work load if needed. Occupational exposure during pregnancy to hazardous material such as biological agents and chemicals like solvents, metals and pesticides can cause foetal loss, birth defects, reduced foetal growth, preterm birth, low birth weight, childhood

13. http://delhihighcourt.nic.in/dhcqrydisp_o.asp?pn=158492&yr=2009

leukaemia and other cancers¹⁴. Infants can be exposed to polychlorinated biphenyls (pcbs), polybrominated biphenyls (pbbs), DDT and other pesticides, organic solvents, mercury and lead through breastmilk. A parent can carry home these hazards to the infant even if it is not brought to the worksite. Cottage industries and some forms of agricultural work can also pose hazards for the infant¹⁵. In rural areas, women agricultural, estate and plantation workers are especially vulnerable as the work is seasonal, and they often have to work with pesticides and other agrichemicals, which are linked with spontaneous abortions as well as cancers, genetic and birth defects, low birth weight, growth retardation in children¹⁶.

14. Thulstrup, A.M. & Bonde, J.P., 'Maternal occupational exposure and risk of specific birth defects', *Occup Med (London)*, Vol. 56, 2006, pp. 532-543; Wennborg, H., Bonde, J.P., Stenbeck, M. & Olsen, J., 'Adverse reproduction outcomes among employees working in biomedical research laboratories', *Scand J Work Environ Health*, Vol. 28, 2002, pp. 5-11; Infante-Rivard, C., Siemiatycki, J., Lakhani, R. & Nadon, L., 'Maternal exposure to occupational solvents and childhood leukemia', *Environ Health Perspect*, Vol. 113, 2005, pp. 787-792; Julvez, J. & Grandjean, P., 'Neurodevelopmental toxicity risks due to occupational exposure to industrial chemicals during pregnancy', *Ind Health*, Vol. 47, 2009, pp. 459-468; Correa, A., Gray, R.H., Cohen, R., Rothman, N., Shah, F., Seacat, H. & Corn, M., 'Ethylene glycol ethers and risks of spontaneous abortion and subfertility', *Am J Epidemiol* Vol. 143, 1996, pp. 707-717; Doyle, P., Roman, E., Beral, V. & Brookes, M., 'Spontaneous abortion in dry cleaning workers potentially exposed to perchloroethylene', *Occup Environ Med*, Vol. 54, 1997, pp. 848-853; Lindbohm, M-L., 'Effects of parental exposure to solvents on pregnancy outcome', *J Occup Environ Med*, Vol. 37, 1995, pp. 908-914; Xu, X., Cho, S.I., Sammel, M., You, L., Cui, S., Huang, Y., Ma, G., Padungtod, C., Pothier, L., Niu, T., Christiani, D., Smith, T., Ryan, L. & Wang, L., 'Association of petrochemical exposure with spontaneous abortion', *Occup Environ Med*, Vol. 55, 1998, pp. 31-36; Chen, D., Cho, S.I., Chen, C., Wang, X., Damokosh, A.I., Ryan, L., Smith, T.J., Christiani, D.C. & Xu, X., 'Exposure to benzene, occupational stress, and reduced birth weight', *Occup Environ Med*, Vol. 57, 2000, pp. 661-667; Yazbeck, C., Thiebaugeorges, O., Moreau, T., Goua, V., Debotte, G., Sahuquillo, J., Forhan, A., Foliguier, B., Magnin, G., Slama, R., Charles, M-A. & Huel G., 'Maternal blood lead levels and the risk of pregnancy-induced hypertension: the EDEN Cohort Study', *Environ Health Perspect*, Vol. 117, 2009, pp. 1526-1530

15. American Academy of Pediatrics Committee on Environmental Health. *Workplaces*. In: Etzel, RA. ed. *Pediatric Environmental Health*. 2nd ed. Elk Grove Village. American Academy of Pediatrics, 2003; Drodzowsky. *Workplace hazards to reproduction and development: a resource for workers, employers, health care providers, and health & safety personnel*. Washington State Department of Labor and Industries. Olympia, 1999

16. Bell. A case-control study of pesticides and fetal death due to congenital anomalies. *Epidemiology*, 2001, 12:148; Berkowitz. In utero pesticide exposure, maternal paraoxonase activity, and head circumference. *Environ Health Perspect*, 2004, 112:388; Garcia. Parental agricultural work and selected congenital malformations. *Am J Epidemiol* 1999, 149:64; Heeren. Agricultural chemical exposures and birth defects in the Eastern Cape Province, South Africa. A case - control study. *Environ Health*, 2003, 2:11; Kristensen. Gestational age, birth weight, perinatal death among births to Norwegian farmers, 1967- 1991. *Am J Epidemiol* , 1997, 146:329; Nurminen. Maternal pesticide exposure and pregnancy outcome. *J Occup Environ Med*, 1995, 37:935; Perera. Effects of transplacental exposure to environmental pollutants on birth outcomes in a multiethnic population. *Environ Health Perspect*, 2003, 11:201; Rojas. Malformaciones Congenitas y exposicion a pesticidas. *Rev Med Chilena*, 2000, 128:399; Schreinemachers. Birth malformations and other adverse perinatal outcomes in four U.S. Wheat producing states. *Environ Health Perspect* , 2003, 111 :1259; Weidner. Cryptorchidism and hypospadias in sons of gardeners and farmers. *Environ Health Perspect*, 1998, 106:793; Whyatt. Prenatal insecticide exposures birth weight and length among an urban minority cohort. *Environ Health Perspect* , 2004, 112:1125

ILO Convention 183, which for the first time recognized pregnant and nursing women's need for health protection, stipulates in Art. 3 that

Each Member shall, after consulting the representative organizations of employers and workers, adopt appropriate measures to ensure that pregnant or breastfeeding women are not obliged to perform work which has been determined by the competent authority to be prejudicial to the health of the mother or the child, or where an assessment has established a significant risk to the mother's health or that of her child

Mbaonly provides for light work for ten weeks (six weeks plus one month) before the date of her expected delivery, if the woman asks for it. There is no mention of hazardous work or finding alternate work. However, as per the 2008 amendment, the minimum medical bonus in case of inability of employer to provide free medical care to pregnant women employee has been raised from Rs 250 to Rs.1000 extending to Rs. 20000¹⁷.

Job protection and non-discrimination

ILO's World Employment and Social Outlook – Trends 2015 notes that the moderate closing of the unemployment gap following the 2008 global economic crisis is currently reversing; overall women continue to suffer from higher rates of unemployment and lower rates of employment, are less likely to participate in the labour force and face higher risks of vulnerable employment¹⁸. In such a situation, non-discrimination and job protection due to maternity become especially important tools to reduce the gender gap and ensure women's continued participation in the labour market.

Both job protection and non-discrimination due to maternity are key features of ILO Convention 183, which recognizes that discrimination can occur not just during the period of pregnancy and lactation, but also during recruitment and hiring.

Though violative of the law, working women often find it difficult to retain their jobs once they announce their pregnancy. While MBA stipulates job protection and non-discrimination, the policies of institutions, both governmental and private are often at odds with the Act. Once again, women have had to take legal recourse to ensure that their rights are met. In the *Air India v. Nergesh Meerza and Ors.* 1981 AIR 1829 case, the Supreme Court struck down the service condition which provided for termination of service of air

17. Press Information Bureau, Government of India, Labour and Employment, Promoting Welfare of Workers, http://pib.nic.in/release/rel_print_page1.asp?relid=46881, 10/08/2014.

18. ILO. World Employment and Social Outlook- Trends 2015. Geneva, January 2015.

hostesses working with Air India on first pregnancy, holding it to be in violation of Article 14 (Right to equality) of the Constitution of India. In the *Mrs. Neera Mathur vs. Life Insurance Corporation of India* the Court denied the corporation the right to ask invasive questions of the petitioner related to her marriage, terming them “embarrassing, if not humiliating”, and ordered the corporation to reinstate the petitioner; however back pay was not given. In the case of *K. Chandrika vs Indian Red Cross Society And Anr*, Delhi High Court ordered reinstatement along with full back pay. Similarly, the High Court of Punjab and Haryana recognized a woman’s right to job protection in the case of *Neetu Bala vs Union Of India And Others* when it directed the Army Medical Corps to appoint Dr. Neeru Bala in the rank of Captain, within a month of receiving the order. Dr. Bala, who had been selected by the Army Medical Corps for grant of Short Service Commission in the rank of Captain, was noted as seven months pregnant when she reported for duty. After some delay, she was intimated vide a letter that as per the competent authority, she was unfit to join service. She had made a request to keep a vacancy for her so that she could join after delivering the child but had received no response.

In the case *Indrani Chakraverty vs. Idiom Consulting Ltd.*, 2012, Indrani Chakraverty brought a criminal case against the design company Idiom Consulting Ltd. For violating MBA. The Delhi High Court issued summons to five officials from the company who, upon discovering her pregnancy, halved her salary, forced her to relocate to Bangalore and then sacked her. The Court ordered that Chakraverty should be paid Rs 7.5 lakh as settlement if criminal proceedings were dropped.

Breastfeeding/nursing breaks and childcare facilities

Currently, the Maternity Benefits Act allows for two paid nursing breaks of 15 minutes each per day till the child is 15 months old. Provision of crèche facilities has been covered in Section 48 of the Factories Act, 1948 and Section 12 of the Plantations Labour Act, 1951; MBA makes no mention of childcare facilities of any kind.

Breastfeeding breaks become meaningless in the absence of childcare facilities. According to a study published in 2012¹⁹, that looked at breastfeeding and working women in four sectors - IT, ITES, Health and Education – in the industrial and commercial hub of NOIDA in the National Capital Territory, a mere 4% (Education and ITES) said that they

19. Shashi Bala. Implementation of Maternity Benefit Act. NLI Research Studies Series. No. 099/2012. V.V. Giri National Labour Institute, Noida.

received nursing breaks in between their working hours. Examining the provision of crèches, the study found that health related institutions had the highest percentage of crèches – 18.5; the lowest was in the ITES sector where 97.5 percent of the institutions did not have any childcare facilities. In the health sector women were using the rest rooms as the feeding rooms to nurse their child who were staying near the place of work.

The situation in the informal sector is equally dismal. Several studies have reported that women want crèche facilities both near their homes and their worksites to enable them to breastfeed their children optimally. Anganwadi centres, located within habitations, would meet this need if they were converted to Anganwadis-cum-creches. However, of the total of 1022.33 lakh Anganwadi centres across the country, only 5% or a little over 50 lakhs are being piloted as Anganwadi-cum-creches. Though laudable, this is nowhere near enough to meet the childcare needs of the children under six years of age. The Mahatma Gandhi National Rural Employment Guarantee Act entitles women workers to avail crèche facility at worksite if the number of children is more than five under the age of five years. The Act stipulates that the crèches should run for 8 to 9 hours during the day and six days in a week and should provide facilities like shade, medical aid, and drinking water. However, this is a catch-22 situation. In the absence of guaranteed crèche facilities, mothers do not want to bring young children to the worksite, which is often far from their homes; without the presence of at least five children, such a facility is not available.

II. Women's Right to Unbiased Information

Given the significance of breastfeeding in determining maternal and child health, there is an increasing demand globally that women's right to breastfeed be recognized as a fundamental human right²⁰. Key relevant international treaties include the ILO's Maternity Protection Convention (MPC), CEDAW and the United Nations Convention on the Rights of the Child, 1989 (CRC).

The World Health Organization (WHO) recommends that WHO recommends that breastfeeding begins within one hour of birth, and continues exclusively for the first six months of the infant's life. Thereafter, breastfeeding should continue till the child is at least two years old, with the addition of appropriate and adequate complementary foods.

20. Kent G. Breastfeeding: a human rights issue? *Development*. 2001;44:93–98. doi: 10.1057/palgrave.development.1110244; Kent G. Child feeding and human rights. *Int Breastfeed J*. 2006;1:27. doi: 10.1186/1746-4358-1-27; Labbok MH, Smith PH, Taylor EC. Breastfeeding and feminism: a focus on reproductive health, rights and justice. *Int Breastfeed J*. 2008;3:8. doi: 10.1186/1746-4358-3-8; UNICEF. How can breastfeeding be a human right? New York: UNICEF; 1998.

As mentioned earlier in this chapter, successful breastfeeding requires the action of two hormones – prolactin and oxytocin – whose production again depend upon how often the baby suckles and the mental and emotional status of the mother. Thus successful breastfeeding requires time, emotional support from one's partner and family, technical and emotional assistance through skilled counseling in case of difficulties, and unbiased information about infant feeding. Given the reality of women's lives, these four factors are difficult to come by when they are needed. Formula companies have taken advantage of the challenges women face and used the role of oxytocin to sow doubts in women's minds about whether the milk their bodies produce is enough to satisfy the needs of their babies.

Of the marketing practices adopted by formula companies, Brun and Dupin explain, "... skillful advertising has succeeded in persuading many women that 'tinned milk bought at the chemists' is better than mother's milk". First of all it is expensive, thus it must be good, and secondly it is sold by people in white coats in the chemists', which must indicate "health value". In areas where the majority of women have little or no education, have no knowledge of elementary hygiene (and even if they learnt it, it is extremely difficult to apply because of living conditions, lack of fresh water etc.), the use of bottles and powdered milk causes thousands of cases of serious gastro-enteritis."²¹ Besides this, the companies woo doctors and nurses with gifts to prescribe formula.

As the links between formula feeding, infant deaths and aggressive marketing by milk companies started becoming clear, in the early 70s, a group of concerned Swiss activists brought out a publication entitled *Nestle Kills Babies*. In 1976, when giving his judgment in a case of libel filed by the giant multinational, the presiding judge admonished the company: "If Nestlé wants to be spared the accusations of immoral and unethical conduct, it will need to change its advertising practices."

The case was a significant milestone in the rising public awareness about the dangers of feeding babies with formula and a growing concern about corporate accountability and was one of the major factors leading to the development of the International Code of Marketing of Breastmilk Substitutes. The Code, which was adopted in 1981 by the World Health Assembly, restricts companies from using aggressive marketing techniques including direct contact between the company representatives and mothers, health professionals and health workers, distribution of free samples and gifts, and health claims. Today, more than 60 countries have translated the International Code into national legislation, which in India is

21. from "Evolution de l'Alimentation dans les pays en voie de développement", de T. Brun et H. Dupin, dans *Cahiers Nut.diét.*, VIII, 4, mars. 1975, cited in Cottingham, Jane, *Bottle Babies: A Guide to the Baby Foods*. Women's International Information and Communication Service, Geneva. Dec 76.p.20

the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992, amended and strengthened in 2003. Since then, Association for Consumers Action on Safety and Health (ACASH) have used the law to stop violations. In 1993, they filed a case against Johnson and Johnson for advertising their feeding bottles, and offering one free bottle for every dozen bought, in contravention of the Act. Further, leading department stores in Mumbai were offering a five percent discount on all products of the company, which including feeding bottles. The case led to written apologies by the company, their advertising company, Lintas and the department store, Shoppers Stop, and in June 1996 Johnson and Johnson stopped manufacturing feeding bottles in India. Acash also filed a case against Wockhardt for using its infant formula brand name Dexolac on all its baby's health products, and thus indirectly advertising its formula brand. They too tendered a written apology and agreed to discontinue this practice. Since then they have highlighted several other cases of violations of the IMS Act, and several times managed to stop such practices

The Nestle Case in India

In October 1994, it was noticed that Nestle had been violating some of provisions of the IMS Act. Cerelac advertisements in Hindi were being featured prominently in articles that promoted the early introduction of foods for infants before the age of four months. This contravened the provisions of the Act, which defined "infant food" as "any food (by whatever name called) being marketed or otherwise represented as complement to mother's milk to meet the growing nutritional needs of the infant after the age of four months". The label on the container of Cerelac read "breast milk" and not "mother's milk" as required by the Act. While the container had the notice in Hindi, the size was much smaller than required by law. This was also found on the labels on tins of Lactogen, the infant milk substitute sold by Nestle. This is significant in the Indian context, because "breast" is often understood as the udder of a cow. Moreover, the notice was printed only in English and not in Hindi. Further, it did not carry a warning that infant milk substitutes or infant foods are not the sole source of nourishment for the infant.

These acts violated Section 6(1) and 7 of the IMS Act; Section 6(1) prohibits any person from producing, supply or distributing any infant milk substitute or infant food unless every container or label affixed to it indicates in clear conspicuous and in easily readable and understandable manner the important notice, titled as such in capital letters in both English and in Hindi as well as in the local language of the place where it is being distributed.

Section 7 further gives the specifics of such labeling: its size, its colour, its positioning, and a warning against health hazards of inappropriate preparation of the infant milk substitute/food. The Sections state clearly that these conditions apply in addition to relevant sections of the PFA.

ACASH filed a case against Nestle in the Delhi Metropolitan Court. A month and a half later, on 16th January 1995, the Metropolitan Magistrate concluded that “there are sufficient matter on the record to summon the accused persons for the violation of 6(i)(a), 6(i)(c) of the Act, read with the rules 6 and 7, punishable u/s 20(2) of the Act.” The case was now officially the State of India vs. Nestle.

On 19th August 1995, the next hearing, the company was admitted on bail on furnishing a bail bond of Rs. 5000/-with one surety bail bond. This amount was patently ridiculous. In 1995, just the income from operations and net sales of the company was over Rs. 990 crores. A significant percentage of this would have come from the sales of Lactogen and Cerelac. At stake were the lives of thousands of infants. What was becoming obvious was that, unlike in the Swiss case against Nestle in the 1970s, the possible malnutrition of these infants and the risk to their lives was not going to be the central issue as far as the court was concerned. It would be the letter of the law rather than the spirit of the law that would be the deciding factor.

Food, especially safe food, is essential to life and health. The Indian Penal Code considers food adulteration a criminal act. However, as the Prevention of Food Adulteration Act (PFA) was concerned only with adulteration; the promotion of infant foods, which were proving to be dangerous for infant health even when they were not adulterated, and their consequences on breastfeeding, was not within the purview of the PFA. The IMS Act was legislated to fill this loophole. Consequently its violations were also considered as criminal acts.

In addition, there existed the possibility that some provisions of the new IMS Act and Rules could be construed as conflicting some of the provisions of older PFA Act. The purpose of the two laws were different - the former to protect and promote breastfeeding by restricting the advertising and marketing practices of products that could undermine breastfeeding and the latter to prevent adulteration and maintain food standards as prescribed by the government. While the government was making efforts to amend the PFA Rules to align them with the provisions of the IMS Act, Dr. B.K. Tiwari, Assistant Director General (PFA), noted in a letter of 9th March 1994 that as far as standards of infant milk substitutes, infant foods and feeding bottles were concerned, the PFA Rules would prevail.

The letter further urged the food inspectors not to harass manufacturers of infant milk substitutes and infant foods “if they are complying (with) the requirements of one of the statute and in doing so the provisions of the other statute (which are not aligned with the other statute) are not complied with.” This was a clear statement of the supremacy of the IMS Act and Rules over the PFA Act and Rules (which were yet to be aligned). However, Tiwari had not used the actual names of the Acts in this sentence, and this lapse was to become a gamechanger. When taken out of context, or read by itself, the sentence could be used by clever lawyers to create confusion, as the Nestle lawyers did later.

Nestle resorted to several tactics besides seeking adjournments to delay the case. Nestle filed a Writ petition in High Court challenging the constitutional validity of the IMS Act. In 2002 in fact the ‘evidence’ went missing from Court premises. In December 2011 the Court ordered to frame Charge on Nestle and Nestle was Charged in 2012.

In May 2013, High Court heard in detail and declared that Nestle should be absolved because the Court believed that Nestle was following one law and it was not possible to follow another law for them. The Court observed:

*“.....15. The approach of the Court in granting relief must be flexible and liberal and not rigid or hyper technical. The Court has a very wide discretion in granting relief under Article 226 of the Constitution of India. The Supreme Court in **Charanjit Lal vs. Union of India, AIR 1951 SC 41** held that a petition under Article 226 should not be thrown away merely on the ground that proper relief is not asked for. Thus, under Article 226 relief can be granted by the Court even by moulding the relief, if justice so requires.*

16. In view of the discussion above, we arrive at the conclusion that inconsistencies existed between the provisions of the PFA Act read with the PFA Rules on the one hand and the IMS Act on the other till the alignment took place on 15.09.1997, so as to make it impossible for the petitioner company to adhere to the provisions of both the enactments simultaneously. It is declared accordingly. Consequently, the writ petition is allowed, in these limited terms....”

Based on this declaration, the High Court order in March 2014 was issued that quashed the order of charge on Nestle in the Metropolitan Court.

Since then, ironically, Nestle has had to face legal challenges from FSSAI regarding both their marketing of infant milks as well as their Maggi noodles. Also, the loopholes in the IMS Act of 1992 were closed with the amendments of 2003. Internationally, the Nestle case in India encouraged other countries like Bangladesh to both strengthen their national legislation built around the International Code and to legally challenge the company’s aggressive advertising methods.

III. Conclusion and recommendations

Maternity protection is extremely complex as it tries to harmonize two seemingly opposing goals – safeguarding and optimizing opportunities for women to realize their right to productive work, while at the same time enabling them to realize their reproductive rights in terms of childbirth and childcare in a way that is best for them and the child. While health care professionals, economists and other academics are agreed that women require some rest before and after delivery as well as time for caring for the baby, especially for exclusive breastfeeding, employers often tend to look at the financial and workload implications. Laws related to maternity protection are among the least stringently implemented, and information about entitlements, where they exist, is sadly lacking among women. Further, as several studies have shown, globalization is making women's employment increasingly vulnerable, pushing them to the informal sector, which is characterized by the lack of labour laws, including laws related to maternity protection. Sex-discrimination at work, especially after pregnancy and childbirth, complicates the situation further. The baby food industry takes advantage of vulnerability of women related to work, whether aspirational or born of financial need, to increase its market at the cost of breastfeeding.

The way forward includes the following:

- a. Universalizing maternity protection by recognizing all forms of women's work as productive work
- b. Paid maternity leave of at least 30 weeks with compulsory four weeks prenatal leave and 26 weeks of postnatal leave
- c. Wage compensation for the informal sector and home makers
- d. Strong health protection component that also guards against using health protection as a pretext to limit women's opportunity for work
- e. Adequate number of breastfeeding breaks at the workplace for a minimum of 15 months
- g. Adequate breastfeeding facilities at the workplace in both formal and informal settings, in the community and markets.
- g. Effective redressal systems
- h. Stringent implementation of legislation
- i. An overarching communication policy that informs women not only of their

maternity entitlements and gives unbiased information on infant feeding, but also of redressal mechanisms in case of violations.

Box 1

Human Rights treaties and maternity protection

Universal Declaration of Human Rights (UDHR), 1948

Art 25(2): Motherhood and childhood are entitled to special care and assistance.

International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966

Art. 10(2): Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period, working mothers should be accorded paid leave or leave with adequate social security benefits.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979

Preamble: Women's right to non-discrimination, including in maternity: leading implicitly to maternity protection at work, to paternity and parental leave, and to understanding society's responsibility towards women vis-à-vis maternity.

Art. 11: Non-discrimination in employment; health and safety at work; prohibits dismissal during pregnancy and maternity leave; maternity leave with pay; services enabling women to combine family obligations and work (child-care facilities); protection against work harmful during pregnancy.

(1): States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular: [...]

(f) The right to protection of health and safety in working conditions, including the safeguarding of the function of reproduction.

(2): In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures:

(a) To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discrimination in dismissals on the basis of marital status;

(b) To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances;

(c) To encourage the provisions of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities;

(d) To provide special protection of women during pregnancy in types of work proved to be harmful to them.

Art. 12.2: ...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.

Convention on the Rights of the Child (CRC), 1989

Art. 18(2): For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.

Art. 18(3): States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

Global Strategy for Infant and Young Child Feeding and maternity protection

Paragraph 4: Scope

Maternity protection legislation should include all working women in agricultural, formal and informal sectors.

Paragraph 12: Specific measures of protection

Women in paid employment can be helped to continue breastfeeding by being provided with minimum enabling conditions, for example, paid maternity leave, part-time work arrangements, on-site crèches, facilities for expressing and storing breast-milk and breastfeeding breaks.

Paragraph 28: Role of governments

Mothers should also be able to continue breastfeeding and caring for their children after they return to paid employment. This can be accomplished by implementing maternity protection legislation and related measures consistent with ILO Maternity Protection Convention, 2000 No. 183 and Maternity Protection Recommendation, 2000 No. 191.

Maternity leave, day-care facilities and paid breastfeeding breaks should be available for all women employed outside the home.

Paragraph 34: National legislation

A comprehensive national policy, based on a thorough needs assessment, should foster an environment that protects, promotes and supports appropriate infant and young child feeding practices...

For protection: Adopting and monitoring application of a policy of maternity entitlements, consistent with the ILO Maternity Protection Convention and Recommendation, in order to facilitate breastfeeding by women in paid employment, including those whom the standards describe as engaging in atypical forms of dependent work, for example part-time, domestic and intermittent employment...

Paragraph 45: Role of employers and trade unions

Employers should ensure that maternity entitlements of all women in paid employment are met, including breastfeeding breaks or other workplace arrangements – for example facilities for expressing and storing breast-milk for later feeding by a caregiver – in order to facilitate breast milk feeding once paid maternity leave is over. Trade unions have a direct role in negotiating adequate maternity entitlements and security of employment for women of reproductive age.

Paragraph 46: Child-care facilities

Other groups: ...child-care facilities, which permit working mothers to care for their infants and young children, should support and facilitate continued breastfeeding and breast-milk feeding.

Paragraph 48: International organizations

Specific contributions of international organizations to facilitate the work of governments include the following: ...to support policy development and promotion;...advocating ratification of ILO Maternity Protection Conventions, 2000 No. 183 and application of Recommendation 2000 No. 191, including for women in atypical forms of dependent work.

Innocenti Declarations, 1990 and 2005

Operational targets (1990)

Target 4: Enact imaginative legislation protecting the breastfeeding rights of working

women and establish means for its enforcement.

Innocenti Declaration on Infant and Young Child Feeding, 2005

Reinforced the original four targets and adopted 5 new ones including

Target 9: New legislation and other measures.

Box 2

Main features of the Maternity Benefit Act, 1961²²

Maternity Leave

The Maternity Benefits Act 1961 allows women to absent themselves from work for a period commencing 6 weeks prior to the anticipated date of birth and finishing 6 weeks after the date of delivery.

Scope

The Maternity Benefits Act applies to all factories, mines and plantations in India, except factories or other establishments to which the Employees' State Insurance Act 1948 applies. However, women who are employed in factories or other establishments to which the Employees' State Insurance Act 1948 applies, but are not entitled to the benefits provided by that Act, are entitled to maternity benefits under the Maternity Benefits Act.

The State Government may extend the scope of the Maternity Benefits Act by decree, following the approval of the Central Government.

Maternity Benefit Act 1961 §§2, 5A, 5B

Qualifying conditions

No woman shall be entitled to maternity benefit unless she has actually worked in an establishment of the employer from whom she claims maternity benefit for a period of not less than 160 days in the 12 months immediately preceding the date of her expected delivery. The qualifying period does not apply to a woman who has immigrated into the State of Assam and was pregnant at the time of the immigration.

Maternity Benefit Act 1961 §5(2)

22. http://www.ilo.org/dyn/travail/travmain.sectionReport1?p_lang=en&p_structure=3&p_sc_id=2220&p_sc_id=2300&p_sc_id=2440&p_sc_id=2480&p_sc_id=2760&p_sc_id=2870&p_sc_id=2790&p_sc_id=3050&p_countries=IN

Remarks: For the purpose of calculating the days on which a woman actually worked, the days for which she has been laid off shall be taken into account.

Duration

Women working in factories, mines and plantations are entitled to absent themselves from work for a period commencing 6 weeks before the anticipated date of delivery to the date 6 weeks after the actual date of delivery.

Maternity Benefit Act 1961 §6

Compulsory leave

No woman shall work in any establishment during the 6 weeks immediately following the day of her delivery or miscarriage.

Maternity Benefit Act 1961 §4(2)

General total duration

12 weeks, being the 6 weeks before the anticipated date of delivery and the 6 weeks following the actual date of delivery.

Maternity Benefit Act 1961 §6(2), (4)

Extension

No provision for extension of maternity leave identified.

Leave in case of illness or complications

A woman suffering from illness arising out of pregnancy, delivery, premature birth or miscarriage shall, upon production of prescribed proof, be entitled to leave for a maximum period of 1 month. Such leave shall be paid at the rate of the maternity benefit. In the case of a miscarriage, a woman shall, upon production of prescribed proof, be entitled to leave for a period of 6 weeks immediately following her miscarriage. Such leave shall also be paid at the rate of the maternity benefit.

Maternity Benefit Act 1961 §§9,10

RELATED TYPES OF LEAVE

No entitlements to related types of leave identified.

RIGHT TO PART-TIME WORK

No entitlement to part-time work identified.

CASH BENEFITS

The Maternity Benefits Act 1961 entitles women workers to cash benefits while on maternity leave.

Maternity leave benefits

Women workers are entitled to up to 12 weeks' maternity leave benefits at the average daily wage.

Scope

The Maternity Benefits Act applies to all factories, mines and plantations in India, except factories or other establishments to which the Employees' State Insurance Act 1948 applies. However, women who are employed in factories or other establishments to which the Employees' State Insurance Act 1948 applies, but are not entitled to the benefits provided by that Act, are entitled to maternity benefits under the Maternity Benefits Act. The State Government may extend the scope of the Maternity Benefits Act by decree, following the approval of the Central Government.

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Qualifying conditions

No woman shall be entitled to maternity benefit unless she has actually worked in an establishment of the employer from whom she claims maternity benefit for a period of not less than 160 days in the 12 months immediately preceding the date of her expected delivery. The qualifying period does not apply to a woman who has immigrated into the State of Assam and was pregnant at the time of the immigration.

Maternity Benefit Act 1961 §5(2)

Remarks: For the purpose of calculating the days on which a woman actually worked, the days for which she has been laid off shall be taken into account.

Duration

The maximum period for which any woman shall be entitled to maternity benefit shall be twelve weeks of which not more than six weeks shall precede the date of her expected delivery.

Maternity Benefit Act 1961 §5(3)

Amount

Every woman shall be entitled to, and her employer shall be liable for, the payment of

maternity benefit at the rate of the average daily wage for the period of her actual absence (100%).

Maternity Benefit Act 1961 §5(1)

Remarks: For the purpose of this entitlement, the average daily wage means the average of the woman's wages payable to her for the days on which she has worked during the period of 3 calendar months immediately preceding the date from which she absents herself on account of maternity, or one rupee a day, whichever is higher (§5(1) Explanation)

Financing of benefits

The employer is required to finance the maternity benefits.

Maternity Benefit Act 1961 §5(1)

Alternative provisions

The Employees' State Insurance Act 1948 provides an entitlement to maternity benefits to insured women subject to certain conditions.

Further, the Unorganised Workers' Social Security Act 2008 provides that the Central Government shall formulate and notify from time to time suitable welfare schemes for unorganised workers on matters relating to health and maternity benefits. The applicable schemes include:

(i) Janani Suraksha Yojana, which is sponsored by the Central Government and aimed at reducing maternal and infant mortality rates and increasing institutional deliveries in below poverty line (BPL) families;

(ii) the National Maternity Benefits Scheme, which provides for the payment of Rs. 500 per pregnancy to women belonging to poor households for pre-natal and post-natal maternity care up to first two live births; and

(iii) the Handloom Weavers Health Insurance Scheme which provides for cash maternity benefit of R2,500 per child (for up to 2 children); and

(iv) the Handicraft Artisans Comprehensive Welfare Scheme which provides for cash maternity benefit of R2,500 per child (for up to 2 children).

Employees' State Insurance Act 1948 The Unorganised Workers' Social Security Act 2008 Handloom Weavers Health Insurance Scheme 2010-2011

Remarks: The Employees' State Insurance Act 1948 applies to factories other than seasonal factories (§1(4)).

MEDICAL BENEFITS

Employers are obliged to provide pregnant workers with a medical bonus or free pre- and post-natal medical care.

Pre-natal, childbirth and post-natal care

Every woman entitled to maternity benefit under this Act shall also be entitled to receive from her employer a medical bonus of one thousand rupees, if no pre-natal confinement and post-natal care is provided for by the employer free of charge.

Maternity Benefit Act 1961 §8 (2008 Amendment)

Remarks: The Central Government may before every three years, by notification in the Official Gazette, increase the amount of medical bonus subject to the maximum of twenty thousand rupees (§8(2) Maternity Benefits Act, 2008 Amendment).

See also the medical benefits available under Janani Suraksha Yojana, which is a welfare scheme sponsored by the Central Government and aimed at reducing maternal and infant mortality rates and increasing institutional deliveries in below poverty line (BPL) families, and the National Maternity Benefits Scheme, which provides for the payment of Rs. 500 per pregnancy to women belonging to poor households for pre-natal and post-natal maternity care up to first two live births.

Financing of benefits

The employer is required to finance the medical benefits.

Maternity Benefit Act 1961 §8

BREASTFEEDING

New mothers are entitled to nursing breaks and factories are required to provide nursing facilities.

Right to nursing breaks or daily reduction of hours of work

Every woman delivered of a child who returns to duty after such delivery shall be allowed 2 breaks of the prescribed duration for nursing the child until the child attains the age of 15 months. Such breaks shall be additional to the intervals for rest allowed to her.

Maternity Benefit Act 1961 §11

Remuneration of nursing breaks

No deduction of wages is to be made by reason only of nursing breaks as contemplated by §11 of the Maternity Benefits Act.

Maternity Benefit Act 1961 §§11, 13

Transfer to another post

No entitlement to transfers identified.

Nursing facilities

In every factory wherein more than thirty women workers are ordinarily employed there shall be provided and maintained a suitable room or rooms for the use of children under the age of six years of such women. Such rooms shall provide adequate accommodation, shall be adequately lighted and ventilated, shall be maintained in a clean and sanitary condition and shall be under the charge of women trained in the care of children and infants.

The State Government may make rules requiring that facilities shall be given in any factory for mothers to feed children under the age of 6 at the necessary intervals.

Factories Act 1948 §48

HEALTH PROTECTION

Health protection measures are established in the Maternity Benefits Act 1961 and are complemented by obligations under the Factories Act 1948.

Arrangement of working time

No employer shall knowingly employ a woman, and no woman shall work, in any establishment during the 6 weeks immediately following the day of her delivery or her miscarriage.

On her request, a pregnant woman shall not be required to do any arduous work, or work involving long hours of standing or which is likely to interfere with pregnancy or the development of the foetus or is likely to cause her miscarriage or otherwise adversely affect her health, during the 10 weeks leading up to the expected date of birth.

Maternity Benefit Act 1961 §4

Remarks: It is anticipated that women will take maternity leave in the 6 weeks leading up to the anticipated date of birth. The entitlement to excuse oneself from arduous work extends to the month preceding the 6 week leave period and any part of the 6 weeks not taken as leave (§4(4)).

Night work

No restrictions specific to night work identified.

Overtime

No restrictions specific to overtime identified.

Work on rest days

No restrictions specific to work on rest days identified.

Time off for medical examinations

No entitlement to time off for medical examinations identified.

Leave in case of sickness of the child

No entitlement to leave in case of sickness of the child identified.

Other work arrangements

No other relevant provisions identified.

Dangerous or unhealthy work

On her request, a pregnant woman shall not be required to do any arduous work, or work involving long hours of standing or which is likely to interfere with pregnancy or the development of the foetus or is likely to cause her miscarriage or otherwise adversely affect her health, during the 10 weeks leading up to the expected date of birth.

Maternity Benefit Act 1961 §4(3), (4)

Remarks: It is anticipated that women will take maternity leave in the 6 weeks leading up to the anticipated date of birth. The entitlement to excuse oneself from arduous work extends to the month preceding the 6 week leave period and any part of the 6 weeks not taken as leave (§4(4)).

NON-DISCRIMINATION AND EMPLOYMENT SECURITY

It is unlawful to dismiss or prejudicially vary the terms of employment of a woman during or on account of an exercise of her rights under the Maternity Benefits Act 1961.

Anti-discrimination measures

It is unlawful for an employer to vary or disadvantage any conditions of a worker's service during or on account of her absence in accordance with the Maternity Benefits Act 1961.

Maternity Benefit Act 1961 §12(1)

Prohibition of pregnancy testing

No prohibition of pregnancy testing identified.

Protection from discriminatory dismissal

It is unlawful for an employer to dismiss a worker during or on account of her absence in accordance with the Maternity Benefits Act 1961.

Maternity Benefit Act 1961 §12(1)

Burden of proof

No relevant provisions identified.

Guaranteed right to return to work

No express guaranteed right to return to work identified. However, employers are prohibited from discharging or dismissing a worker, and from varying a worker's conditions of employment to her disadvantage, during her absence on maternity leave.

Maternity Benefit Act 1961 §12(1)

Sterilization in India

Jibin Matthew & Madhulika Masih

Introduction

For a country which rose to freedom with a literacy rate of just over 12%¹ and the awareness of a possible fewer, India's population running in tens of millions was a handicap too great to be overcome by PM Nehru's iconic 'tryst with destiny.' India was, and still remains, a nation that lives and thrives in its hundreds of villages, where the population boom remained uninhibited despite the many natural and man-made setbacks that came in its way. Family planning in fact was a policy raised to tackle this very handicap, a possible solution to the dilemma of providing acutely short services through overstretched resources to an ever-growing population. In other words, family planning in India was meant to restore some semblance of parity between the population and the capacity of the State to provide for society's economic and social needs.

What does family planning entail? A significant part of the universal strategy on family planning hinges on the awareness of the target population. In India, however, awareness and knowledge are the primary areas which need work. Even where such knowledge is available, family planning remains to be seen as socially unacceptable, a taboo, an insult to the Indian family. Today, most countries across the world have adopted family planning programmes. What is worrying in the Indian context, however, is its focus on the permanence of family planning, and its reliance on sterilization.

In India, as in many other developing countries, sterilization drives have been regarded as the definitive solution to the ever burgeoning population boom. From the early days

1. *"A students' history of education in India"* (1800–1973) (6 ed.). Macmillan.

of independence when India became arguably the first country to have a state-sponsored family planning programme, to the 1970s when the State blatantly used the promise of land and money to get thousands sterilized en masse, and finally to the current state of affairs when the success of such drives is measured by the not-so-subtle 'Expected Level of Achievement,' such initiatives have had a long and troubled history in India.

However, despite the many lofty intentions and targets set by the State over the past few decades, the cruel reality remains that for thousands, sterilization has not been as easy and painless as advertised. In fact, as this chapter shall discuss, most of these sterilizations have been accompanied by a flurry of complications, aided by a combination of inadequate training, ill-hygiene, wrongful incentivisation and a bypass of informed consent and awareness of procedure, among others. In fact, these factors have actively contributed to the over 700 deaths in the period 2009-2012 plus another 356 victims who have borne complications resulting from improperly done sterilization procedures.²

Perhaps, primary among the tendencies plaguing India's sterilization programmes are their overdependence on sterilizing people en masse. The camp culture, or as Al-Jazeera notes 'cattle culture,' is rampant as hundreds and thousands are grouped together to be sterilized at once. India reported over four million sterilizations for the year 2013-14, only a few million lower than the 6.2 million the State sterilized during the State-imposed Emergency, where freedoms and fundamental rights were curtailed indiscriminately. These figures are put into better perspective by Science journalist Mara Hvistendahl who states that India had sterilized more people than the Nazis during the Emergency.³ Further, such sterilization initiatives and India's family planning policies in general, are hitting the country's poor and underprivileged, especially the women, the hardest.

A lot of such failure to adequately implement the sterilization drive has to do with a potent combination of lack of basic medical facilities, lack of trained professionals and doctors and lack of empathy towards patients. In the rural areas where sterilization drives are actually more prevalent than in the cities, many of such programmes are conducted in the absence of adequate medical facilities which cater to patients, both pre and post-operation. In most cases, patients are housed in tents by the hundreds, where health and hygiene standards are often substandard. Additionally, most of these surgeries are operated by State-employed surgeons who do not necessarily have the training or the expertise to do such surgeries.

2. Annexure to Lok Sabha Unstarred Question No. 4404 for 07.09.2012

3. SoutikBiswas, "India's dark history with Sterilization," 14 November 2014 <<http://www.bbc.com/news/world-asia-india-30040790>>

Moreover, as recent trends suggest, vasectomy on men is falling while tubectomy on women, considered far more delicate and dangerous is rising in numbers.⁴ Even as monetary incentives are sought to be given to much of such patients, the growing initiative of the State in favour of tubal ligation over vasectomy may reflect an innate sexism in the Family Planning programme, especially since the latter is still very much a cultural taboo.

Then there is the matter of informed consent, a fact that has long plagued India's sterilization programmes. Most of India's patients/volunteers are coerced for such programmes, or in the name of incentives, are herded to such surgeries without informing them of the consequences of the same.

India's family planning programme, especially its sterilization initiatives have focused exclusively on target-oriented population control, rather than evenly addressing the reproductive rights of a woman. As a result of an initiative driven more by the goal of achieving targets, the State machinery, especially in the rural areas, has been foregoing its duty and obligation to maintain woman's health and dignity. As Shree Venkatram of the Population Foundation of India notes, "Family planning saves lives. When it ends up taking the lives of young mothers, or inflicting them with lifelong sickness, it is a monumental tragedy. And it has the potential of setting back the programme by decades."⁵

The purpose of this chapter on sterilizations in India is multi-faceted. It traces the history and evolution of family planning and sterilization initiatives in India and addresses the issues that plague this initiative in India. Further, it shall attempt to reflect on the fallacies of this programme, as well as suggest ways by which this programme may be made uniform and people-friendly in the future, supplemented by the many case laws pertaining to this respect.

Historical Developments

India has had a long, turbulent history of proactively pursuing family planning and family welfare. In fact, it can be traced back to the year 1935, when the National Planning Committee under the Indian National Congress first described the issue of a booming, uninhibited rise in population as a hurdle against the interest of social economy, family happiness and national planning.⁶

4. Geeta Pandey, "Why are Indian Women going to Sterilization Camps," 11 November 2014 <<http://www.bbc.com/news/world-asia-india-29999883>>

5. Shree Venkatram, "India's family planning must give way to proper family planning," Accessible at: <http://www.theguardian.com/global-development/poverty-matters/2014/nov/22/india-sterilization-camps-family-planning-tragedy>

6. 'The status of family planning in India: An introduction,' Family Health International India, <<http://www.fhi360.org/sites/default/files/media/documents/india1-family-planning-status.pdf>> Accessed on 01.04.2016

It was this very hurdle that the INC government, led by Prime Minister Jawaharlal Nehru, vowed to overcome with the institution of the National Family Welfare Programme under the auspices of its first Five-Year Plan of 1952.

It is here that the story of R.A Gopaldaswami, a demographer in post-independence India should be mentioned. A man with an exceptional grasp of both language and arithmetic, he would be tasked with the responsibility of conducting independent India's first nationwide census.⁷ The results he presented were staggering in their proportionality. India in 1951 had over 356 million people with a life expectancy of just over thirty-five, out of which only 12% could be safely known as literates. Out of the millions of women, the average number of children a woman had in her lifetime was six while about one-fifth of all infants born would never live to see their first birthday. According to his calculations, India would annually be adding over 500,000 people to the global demographic. It was in this respect that in his report Gopaldaswami suggested a practice unknown in the developing world: that of mass sterilization. "It is nearly as certain as any prediction can be that India's population will rise to 520 million by 1981," he said, according to a 1954 Washington Post article, adding that any plan to get more food would not be enough. How, he asked, would India feed all these people? Better to sterilize anyone with three children or more.⁸

The idea of family planning was not new to those who were responsible for government policy in the 1950s. This is evidenced by the institution of the National Family Welfare Programme by the INC in as way back as 1935. However, it was perhaps Gopaldaswami's report that set the fuse to India's willingness to institute a policy that sought to curtail the exponential, Malthusian-like⁹ nature of India's booming population.

In order to inhibit this Malthusian growth in population, Gopaldaswami suggested Malthusian measures to take care of them. According to Robert Malthus, there were two types of checks that could reduce a population's growth rate: the first being preventive checks and the second being positive checks.

Preventive checks were voluntary actions the population may take to avoid contributing to its own growth. On the other hand, positive checks included anomalies such as disease, famine etc.

7. Terrence McCoy, *The forgotten roots of India's mass sterilization program*, 'The Washington Post 15.11.2014, <<https://www.washingtonpost.com/news/morning-mix/wp/2014/11/14/the-malthusian-roots-of-indias-mass-sterilization-program/>> Last accessed on 01.04.2016

8. *Ibid.*

9. Thomas Robert Malthus was English sociologist and scholar of the 18th century who is widely credited with his theory on population. His theory was based on the relationship between population growth and resources. The basic premise of his theory was that population growth always rises exponentially and eventually, will outstrip and outgrow the resources available for them.

Gopaldaswami's suggestion of mass sterilization was an illustration of preventive checks under Malthusian population theory. Sterilization has always been the more permanent of checks on population growth. Mass sterilization, however, was an experiment made almost inevitable by India's massive population and the shared concern that such a population is more of a liability than a dividend.

However, mass sterilization as we know it today, did not follow Gopaldaswami's report. Sterilizations became part of the state's family planning policies, but mass sterilizations did not and forced sterilizations certainly did not. In fact, there was a belief in the higher circles of the State that India could repeat the experiences of much of the developed where industrialization and a consequential improving standard of living had been accompanied by a marked fall in the rate of population growth. In the 1950s, although India witnessed a marked rise in the number of hospitals and medical health care facilities where birth control information was readily available, the State did not make an aggressive effort at population control and handily ignored Gopaldaswami's Malthusian suggestions for population control. The fear of an imminent 'population explosion' was thus disregarded and a supportive, if not robust family planning programme found its way into practice in post-independent India.

However, this side-policy of family planning and welfare witnessed a dramatic change in the late 1960s and 1970s with the predicted 'population explosion' on the horizon. Gopaldaswami had predicted India to have a population of over 520 million by the year 1981. However, India's population surprisingly passed that mark over a decade earlier. By 1981, it would reach a number of 683 million, with estimates of 10 million people added to the staggering population every year.¹⁰ This was the beginning of a state-backed family planning policy that was to evolve into the robust, almost mechanical programme we know it to be now. From viewing development as the best contraceptive and the biggest hurdle to population growth, the state policy marked a radical change to the right as a more permanent method came to be aggressively pursued: sterilization.

Sterilizations became commonplace and were even actively encouraged by the State in return for monetary sums and incentives. The early 1970s became the period which began to be identified with sterilizations en masse, even though a large part of it was still voluntary in nature. The element of consent in Malthusian preventive checks was therefore still in place.

The National Population Policy of 1976 reflected the growing consensus among policy makers across India of the trouble to economic growth posed by the population explosion. The voluntary aspect of Malthusian policy on population control was let go of and from

10. See *Supra* Note 7

rewarding men with transistor radios for undergoing vasectomy, the state went on a spree of compulsory sterilization, a policy almost always achieved by forcefully herding hundreds of men on the back of trucks to sterilization camps. It was, as described by an officer on the scene, “police literally dragged people in from the fields to the vasectomy table.”¹¹

This was the time of the National Emergency imposed by PM Indira Gandhi, and aided by her son Sanjay Gandhi whose five-point programme which included population control, was at the forefront of India’s horrific sterilization initiative during the period of 1975-77. During those two years, millions across India – mostly men – were carted off to be sterilized, not only those who already had children, but even men who were childless and many who were not married or still in puberty. To put it into perspective, it is estimated that over 6 million people were sterilized in 1976 alone, more than the number of people sterilized by Nazi Germany before 1939.¹²

The story of compulsory sterilization ended with the Emergency in 1977. However, the huge backlash against the forcefulness of such a reprehensible policy meant that other population growth measures would be stalled for years.

During the 1980s, an increased number of family planning programmes were implemented through the state governments with financial assistance from the central government. In rural areas, the programmes were further extended through a network of primary health centers and sub centers. By 1991, India had more than 150,000 public health facilities through which family planning programs were offered. Four special family planning projects were implemented under the Seventh Five-Year Plan (FY 1985-89).¹³ One was the All-India Hospitals Postpartum Programme at district and subdistrict-level hospitals. Another programme involved the reorganization of primary health care facilities in urban slum areas, while another project reserved a specified number of hospital beds for tubal ligation operations.

Despite these developments in promoting family planning, the 1991 census results showed that India continued to have one of the most rapidly growing populations in the world. Between 1981 and 1991, the annual rate of population growth was estimated at about 2 percent. The crude birth rate in 1992 was 30 per 1,000, only a small change over the 1981 level of 34 per 1,000.¹⁴

Through all this, however, sterilization remained a principal method of population control.

11. See *Supra* Note 5

12. See *Supra* Note 3

13. *India – Population and Family Planning Policy*, <<http://countrystudies.us/india/34.htm>> Last accessed on 01.04.2016

14. *Ibid.*

The days of forced sterilizations done en masse had passed, but the state had continued to push and encourage the population to opt for sterilization, often with monetary incentives. Further, throughout the ensuing decades, much of India's sterilization programme, forced or otherwise, was driven by targets: a set number of men and women that must be sterilized by the state over a period of time.

Some degree of sanity, however, was retained when after the International Conference on Population and Development, 1999 India adopted a target-free, reproductive health regime under the National Population Policy of 2000 (This would in turn evolve into the National Rural Health Mission by the year 2005).

However, despite official State policy which dictates that sterilizations must be conducted target-free, there is evidence to suggest that unsaid and unspoken targets remain to be achieved by doctors on the ground, as well as ASHA workers and others of their kin who are told to keep up with the more ambiguous 'expected level of achievement.' Even today, family planning policies at the grassroots level remain dictated by targets, even if the National Population Policy states otherwise, and even if various national and State-level governments continue to deny its existence.

Major Issues

Sterilization in India is beset with a lot of reproductive health right issues and problems, which are perhaps inherent to India's family planning policies since independence. The biggest issue in the programme is the belief that sterilization is the end of all things, that it is the best suited method to tackle the growth of population in India. Whatever the effectiveness of sterilization may be, the blueprint of its implementation in India is riddled with faults and fallacies.

And the statistics reflecting this reality are horrific. In India, 37% of all women between the ages of 15 and 49 have been sterilized, half of them sterilized before the age of 37.¹⁵ It is argued that 4.5 million women are sterilized in India annually.¹⁶ There have already been 1,434 deaths due to sterilization procedures between the years 2002 and 2013, 58 of them happening between 2009 and 2012.¹⁷

15. International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005-06. India: Volume I. Mumbai: IIPS - See more at: <https://www.pop.org/projects/stop-forced-sterilizations-india#fn1>

16. *Ibid.*

17. Jason Clarke, "India's Mass Sterilization," 12 November 2014 <<http://www.theguardian.com/world/2014/nov/12/india-sterilisation-deaths-women-forced-camps-relatives>>

Instead of opening sterilization as a safe alternative to other family planning methods on a voluntary basis, there is now a herd culture prevalent where people are sterilized in hordes in sub-standard conditions, where a simple surgery may turn out to be fatal in its consequences.

Some of the major issues plaguing the services of sterilization in India include:

Camp Culture

The system of administering sterilization in India is what Al-Jazeera famously called a 'cattle culture.'¹⁸ People for such camps are brought in hordes, en masse as tens and thousands of people are sterilized over the course of a few days. With the responsibility to ensure that such services are provided to so many people, the attitude of the administration is largely careless and irresponsible.

The major problem with such camps is the fact that none of them are adequate or capable to provide healthy services to anyone attending them. Most camps only have limited facilities at their disposal. This is a definite consequence of the fact that most of them are located in makeshift facilities such as schools, which are in no way equipped to administer pre and post-surgical care to patients, men and women alike.

These camps are often conducted without the permission of state medical authorities and even if they have been sanctioned, such camps are organized without fulfilling the necessary formalities of conducting such a camp. Camps do not have quality assurance committees, which is why they often have below par standards of health, hygiene and sanitation. By allowing the sterilization of masses, camps facilitate the stretching of acute resources which the camp has in the first place. As a result, men and women who come for these services are often left bleeding outside after operations, which are often performed with unsterilized instruments, without any post-surgical care of any sorts.

Consider the case of Araria, Bihar where 53 women were sterilized in a matter of just hours in dirty, unhygienic conditions in a makeshift facility created in a school.¹⁹ Also consider the case of West Bengal where 103 women were similarly sterilized furiously quickly in a 'Mega Ligation Camp.'²⁰ Then, there is the more infamous instance of the

18. Lisa Le Bode, "Why Indian Women are victims of sterilization 'Cattle Camps,'" 14 November 2014 <<http://america.aljazeera.com/articles/2014/11/14/women-india-sterilization.html>>

19. Shoumijit Bannerjee, "Barrack-room surgeries in Bihar's backwaters," 32 January 2012 <<http://www.thehindu.com/todays-paper/tp-opinion/barrackroom-surgery-in-bihars-backwaters/article2824008.ece>>

20. Soudhriti Babani, "Women dumped on field after Sterilization drive," 7 February 2013 <<http://indiatoday.intoday.in/story/women-dumped-on-field-after-sterilisation-drive/1/249324.html>>

camps in Chhattisgarh where 140 women were similarly sterilized in horrific conditions leading to the deaths of over a dozen, largely due to septicemia.²¹

The camp approach is heavily associated with the sterilization of women, where it has attracted intense national and international condemnation for its perpetuation of gender and caste discrimination and flagrant, systemic violations of Government mandated guidelines on the quality of care, including the negation of informed free choice and persistence of substandard conditions at camp facilities. Therefore, this focus on sterilization camps as a means to fulfill sterilization targets is a violation of the right to live with dignity and the right to freedom from torture and cruel, inhuman or degrading treatment, which is implicit in Article 21 of the Indian Constitution. Additionally, it has been found by a Human Rights Watch report that certain state approaches to female sterilization ‘forced doctors in the public hospital to commit so much staff time to sterilization camps that other basic reproductive health care suffered.’²²

Target-based Approach

Unfortunately, despite the positive steps taken by the State in the late 90s and the paradigm shift marked by the National Population Policy of 2000 which eliminated numerical targets for sterilization or the number of people that must be sterilized, reality confirms that that district and sub-district authorities continue to assign individual yearly targets for contraceptives, with a heavy focus on female sterilization.

Therefore, whilst ‘top-down’ targets have officially been eliminated, this has merely been replaced by the emergence of ‘bottom-up’ targets and quotas couched in the euphemistic phrase, ‘Expected Level of Achievement’. In practice, State-level authorities and district health officials continue to be pressured to achieve targets through a system of financial incentives including monetary payments, or are otherwise threatened with salary cuts, negative performance assessment, suspension and dismissal. Numerous reports and studies confirm that grassroots health workers face immense pressure from their superiors to achieve targets. In a report published by Human Rights Watch, several health workers alleged that they were humiliated and verbally abused by their supervisors for not motivating enough women to accept contraception, while others were suspended from their jobs. Supervisors are not in regular contact with the local community and have no personal relationship with

21. “Medical Negligence, Sub-standard drugs cause Sterilization tragedy,” 26 August 2015 <<http://www.firstpost.com/india/medical-negligence-sub-standard-drugs-caused-chhattisgarh-sterilisation-tragedy-panel-2409264.html>>

22. “India: Target-driven sterilizations harming Women,” July 12, 2012 <<https://www.hrw.org/news/2012/07/12/india-target-driven-sterilization-harming-women>>

the women that the health workers are seeking to motivate. They are therefore insensitive to the needs and opinions of the women.

The target-based system represents a state-sanctioned violation of sexual and reproductive rights, and inevitably results in a substantial deterioration in the quality of care.

The negative impact of targets on basic reproductive health care is further highlighted by the fact that local health workers will dedicate most of their time on fulfilling targets and subsequently spend less time and resources on distributing timely supplies of other contraceptive methods and on providing other essential reproductive health services.

Gender-bias

There is an ingrained gender bias against women within the ranks of India's sterilization programme. Instead of spending resources and energy on more and effective awareness programmes, especially among men, national and state health budgets focus mostly on the administration of sterilization services to women. In fact, a report had suggested that vasectomies, or sterilizations on men, accounted for a mere 4% of all sterilization procedures in India.²³ Further, another report suggests that less than one percent of men undergo sterilization procedures while four out of ten women undergo tubectomy operations.²⁴ This is highly problematic, considering the fact that compared to tubectomies, vasectomies are much easier and safer to perform.

A lot of the reasoning behind such bias lies in the faulty idea of manhood and the persisting social norms on masculinity that finds its way not only into society, but in the public health care system as well. In a traditionally patriarchal society such as in India, anything that might affect any man's masculinity or virility is considered taboo. For many, a man who undergoes such a procedure is an outcaste, incapable of procreating children who may extend his line. Further, there are many who associate sterilization with a loss in sexual potency. Such an attitude subscribed to by the society has therefore permeated the general policy strategies of the health care system as well.

This gender bias additionally has a lot to do with the fact that there is a widespread belief that women can be coerced, or even forced into a sterilization procedure, which they do not

23. Mavalankar, Dileep; Sharma, Bharti, *"The Quality of Care in Sterilization Camps: Evidence from Gujarat. : In Improving Quality of Care in India's Family Welfare Programme"*. Population Council. 1999. p.293-313. ISBN 0-87834-099-8

24. Raksha Kumar, *"India's Lethal Contraception Culture,"* 8 February 2015 <<http://america.aljazeera.com/multimedia/2015/2/female-sterilization-in-india.html>>

have full information about. Authorities believe that women are less likely to complain and are therefore, easier targets for such operations. ASHA workers for instance, rarely approach men to undergo such sterilization operations.²⁵

Such a bias, unconscious or not, hits women who are poor and underprivileged and who are members of minority groups the hardest, as their access to information, education, and legal recourse is particularly limited.

Lack of Informed Consent

As has been aforementioned, women make easy targets for sterilizations because authorities believe they are less likely to complain about such procedures. Part of the reason behind it is that women are not completely informed or are misinformed because apparently, they are believed to be capable of being easily coerced or manipulated.

There have been cases where patients have been carted off for ‘minor’ operations, only to come out incapable of bearing a child ever again.²⁶ As health care service providers, it is the duty and responsibility of doctors, nurses and ASHA workers to duly inform such women about the nature, consequences, positive and negative implications or side-effects of the said procedure and yet, as is the case most of the time, these providers fail to do their duty by skimming through the details of the procedure.

Such an issue is further made worse by the low rates of literacy among rural women, who constitute the significant populace participating in the said sterilization drives. Such an anomaly does not resolve the issue, even after the State has mandated written forms for consent as most of these women can’t read or write. It is therefore left for these women to trust their health care providers blindly, in an extension of that faith placed in a doctor by his patient.

Futility of Family Planning Indemnity Scheme

With sensitive operations such as a sterilization procedure, it is important for there to be some form of accountability against those who are responsible for providing these health care services. However, where such procedure is unsuccessful, punitive actions against such service providers responsible is sorely lacking.

25. Aditi Malhotra, “*Why Indian Men don’t get sterilized,*” 13 November 2014 <<http://blogs.wsj.com/indiarealtime/2014/11/13/delhis-mega-vasectomy-camp-and-why-indian-men-dont-get-sterilized/>>

26. “*Teen tricked Into Sterilization Surgery,*” 21 March 2015, <<http://timesofindia.indiatimes.com/city/gurgaon/Teen-tricked-into-sterilization-surgery-was-told-it-was-vaccination-camp/articleshow/46641098.cms>>

The Family Planning Indemnity Scheme (FPIS), however, was a scheme to ensure a form of monetary recourse to such a failure in sterilization operations. A failure in this case includes death or permanent injury to the patient, as well as a case where a 'sterilized' man or woman is able to procreate.

For instance, under the scheme there is a compensation of Rs 50,000 – Rs 2 lakh for death caused by a sterilization procedure. Further, where a sterilization procedure has failed, there is a compensation of Rs 30,000.

However, the scheme itself is beset with a lot of problems which include,

1. Patients are not made aware and informed of the existence of the scheme. The knowledge of those who have these procedures performed on them and the ASHA workers is restricted to the amount of incentive money they are entitled to after such surgery, another instance that is evidence of the State's failing effort to fully inform the general public. As a result, the provisions relating to the compensation that can be claimed in the event of a death, failure or complications following the sterilization remain unknown to a majority of the public.
2. In the event of any complication due to the surgery, the acceptors lose their faith in the government hospital's facilities and prefer to avail the services at a private hospital where they then have to shell out exorbitant amounts of money.
3. Another issue seen is the lack of awareness about the scheme among the Government. Health officials/service providers and ASHA workers who are entrusted with the responsibility of creating awareness about family planning are themselves unaware of the various family planning policies of the government in place.
4. Even when FPIS is made aware and is known to people, the entire process of claiming compensation under the scheme is lengthy and drawnout. The claim process, considering it is of an urgent nature, is instead made cumbersome and draining for the party concerned.

Looking Ahead

As has been established, sterilization in India is a major issue unless there is an iota of responsibility among those who are charged with providing these services, including the State and other health care professionals. Callousness and apathy has led to sterilization being dubbed as the most unsafe of all family planning programmes, which is ironic considering the heavy focus on sterilization placed by India's family planning initiatives.

It is in this regard that the landmark judgment of the Apex Court in *Ramakant Rai v. Union of India* should be mentioned. This petition had been filed by social activist Devika Biswas against the atrocious conditions in which sterilizations were being conducted across the country, endangering the lives and mortality of hundreds of men and women. It was here, that the Apex Court issued several guidelines with respect to sterilization operations in India, which States and service providers must ensure while organizing and performing sterilizations in the future. In writ Petition (C) 209 of 2003 decided on March 1st 2005, the Supreme Court made an order in *Ramakant Rai (I) vs. Union of India and all the States/ Union Territories*, which can be summed up as:

- a. Introduce a system of having an approved panel of doctors and limiting the persons entitled to carry on sterilization procedures in the State to those doctors whose names appear on the panel.
- b. The State Government shall also prepare and circulate a checklist which every doctor will be required to fill in before carrying out sterilization procedure in respect of each proposed patient. The checklist must contain items relating to (a) the age of the patient, (b) the health of the patient, (c) the number of children and (d) any further details that the State Government may require on the basis of the guidelines circulated by the Union of India. The doctors should be strictly informed that they should not perform any operation without filling in this check list.
- c. The state Governments shall also circulate uniform copies of the proforma of consent.
- d. Each States shall set up a Quality Assurance Committee which should consist of the Director of Health Services, the Health Secretary and the Chief Medical officer, for the purpose of not only ensuring that the guidelines are followed in respect of pre-operative measures, operational facilities and post-operative follow ups.
- e. Each State shall also maintain overall statistics which give a breakup of the number of the sterilizations carried out, particulars of the procedure followed, the age of the patients sterilized the number of children of the persons sterilized, the number of deaths of the persons sterilized either during the operation or thereafter which is relatable to the sterilization etc.
- f. The State Government shall also take punitive action against anyone in breach of these guidelines, over and above an enquiry. As far as the doctors are concerned, their names shall, pending enquiry, be removed from the list of empanelled doctors.

- g. The state shall also bring into effect an insurance policy.
- h. The Union of India shall also lay down the norms of compensation which should be followed uniformly by all the states.

Unfortunately, however, the conditions which were pre-existing prior to the order of the Apex Court in the aforementioned case prevail even now. Evidence of recent tragedies in Bihar²⁷ and Chhattisgarh,²⁸ among a catalogue of other tragedies seems to reflect that the State's barbaric and inhumane practice of enforced sterilization continues to violate every reproductive right of man and woman. Sterilization may be a solution to a booming population growth, but it is a drastic one, a solution which must be driven by informed choice, rather than calculated coercion. Even where it is done on people who willingly come forward for the procedure, sterilization has been known to be done in the nastiest of conditions, endangering the life and health of one and all.

It is in this regard that various changes should be made with regard to the State's practice of sterilization:

1. The system of 'sterilization camps' as it exists today should be struck down. Delicate procedures such as tubectomy and vasectomy must not be conducted in makeshift facilities set up in schools. It should only be allowed in accredited medical health care centres. Also, the persisting culture of sterilizing people en masse should be avoided so as to ease workload on the service providers.
2. The State should take responsibility for the existence of low-level targets set by medical authorities at the state and district level. The State should also declare sterilization targets as inherently coercive and in violation of the rights to bodily integrity, individual autonomy and health.
3. The focus of family planning in India should be broadened. The budgets for sterilization services should be cut and instead must be pooled in a larger campaign for spreading family planning awareness in the society, especially amongst men. People should be made aware of alternative family planning options, which are much safer and temporary in nature compared to tubectomies.
4. Quality Assurance Committees should be set up at State and district levels to ensure that the basic standards of hygiene and medical propriety are maintained wherever such sterilization services are being provided.

27. See *Supra* Note 19

28. See *Supra* Note 21

5. Surgeons/gynecologists should verify that each client has been adequately counseled and screened, by filling out a checklist before conducting the procedure. Requisite equipment/instruments and supplies, as well as emergency and surgical procedures should be provided for at all times. Post-operative instructions on the records of all cases should be documented.
6. The state should publicize on radio and television the content of the orders passed by the Supreme Court in Ramakant Rai's case and information about family planning insurance schemes. Further, the medical authorities should provide documentation of sterilization procedures done to the families of the deceased or anyone incapacitated by the procedure.

International Law

India has arguably the oldest family planning programme in the world. Therefore, it is expected that such antiquity will be the norm for international standards on family planning, and specifically sterilization to be built upon.

However, India's failure to implement the Ramakant Rai guidelines and to change its present family planning policies is complimented by its inflexibility to accept or agree to accept international standards and norms attached to sterilization. It is therefore necessary that light be shed on the available provisions under international law relating to sterilization.

Article 16 of the UN Declaration on Human Rights states that, "Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family."

Further, the Rome Statute of the International Criminal Court, 1998 recognizes enforced sterilization as a crime against humanity.

Article 7.1 (g) states that, 'Rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity.' It must be stated however, that India is a non-signatory to the statute.

In the case of *I.G. and others v. Slovakia*, heard in the European Court of Human Rights (ECHR), dated 13.11.2012:

The case concerned the sterilization of three applicants from Roma ethnicity at Krompachy Hospital without their informed consent.

In their application, the applicants alleged the violation of Articles 3 (No one shall

be subjected to torture or to inhumane or degrading treatment or punishment), 8 (Everyone has the right to respect for his private and family life), 12 (Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right) and 14 (The enjoyment of the rights and freedoms set forth in the Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status in relation with their sterilization).

Here the Court, taking into account the nature of the intervention, its circumstances, the age of the applicant and the fact that they belong to a vulnerable population group held that, their individual reproductive rights were violated by such acts of coerced sterilization

In the case of *Republic of Namibia v LM and Others*, dated 3.11.2014, the respondents were three female Namibians with HIV positive status who were sterilized by way of a surgical procedure or operation known as bilateral tubal ligation (BTL) at two separate State hospitals on different occasions in 2005 and 2007.

The Court held that none of the respondents gave informed consent because they were in varying degrees of labour and may not have fully and rationally comprehended the consequences of giving consent for the sterilization procedure.

The country's High Court ruled that medical personnel at public hospitals violated the rights of three HIV-positive women when it sterilized them without their consent. The government appealed that decision, and the Supreme Court rightly rejected that appeal.

In the Canadian case of *Muir v. Government of Alberta*, dated 25.01.1996, Leilani Muir became the first sterilization victim to win a judgment against the Government of Alberta. She was awarded damages totaling \$740,000 for wrongful confinement and for wrongful sterilization.

The Court held that, 'the damage inflicted by the operation was catastrophic and the circumstances of Ms. Muir's sterilization were so high-handed and so contemptuous of the statutory authority to effect sterilization, and were undertaken in an atmosphere that so little respected Ms. Muir's human dignity that the community's, and the court's, sense of decency is offended.'

In Sweden, law required all transgender people to undergo sterilization if they want to legally change their sex. Sweden's 1970s-era statutes on sexual identity mandated that any person who legally wanted to change their sex must be sterile. Transgender Swedes had to go

through gender reassignment surgery to have their legal documents updated, and to comply with the law, they were also sterilized, whether or not they wanted to be.

In a 2012 case, the Swedish Court of Appeal in held that,²⁹ ‘The question in this case is if the sterilization requirement set out in paragraph 1 of the Gender Determination Law conforms with the prohibition of forced bodily intrusion in 2 Ch. Paragraph 6 of the Instrument of Government and the ECHR right to private life (Article 8) and the prohibition of discrimination (Article 14)’

‘To this end it is added that the requirement to go through the intervention cannot be seen as voluntary. According to the Administrative Court of Appeal’s assessment the sterilization requirement is thus such a violation of integrity which cannot be seen as compatible with 2 Ch. Paragraph 6 of the Instrument of Government and Article 8 ECHR.

The law was therefore declared unconstitutional on 19.12.2012.

29. <http://newsfeed.time.com/2013/01/14/transgender-people-in-sweden-no-longer-face-forced-sterilization/>

Right to Education in India

Ramakant Rai

Education is the great engine of personal development. It is through education that the daughter of a peasant can become a doctor...that a child of farm workers can become the president of a great nation. It is what we make out of what we have, not what we are given, that separates one person from another. - Long Walk to Freedom:

The Autobiography of Nelson Mandela (1994, p.144)

Introduction

In 1990, the world's nations committed themselves to achieve universal primary education (UPE) and reduce illiteracy by the year 2000 at the World Conference on Education for All (EFA) in Jomtien, Thailand. As the new millennium approached, it was clear that many countries were still very far from reaching these targets, so the international community met again at the World Education Forum (WEF) in 2000 in Dakar, Senegal, and committed themselves to achieving EFA by 2015. The Dakar Framework for Action pledges to expand learning opportunities for every child, youth and adult through six key goals:

- Expand early childhood care and education
- Provide free and compulsory primary education for all
- Promote learning and life skills for young people and adults
- Increase adult literacy by 50%
- Achieve gender parity by 2005 and gender equality by 2015
- Improve the quality of education

Both the Millennium Development Goals and the “Education for All” goals should have been met in 2015, but by now we know that none of the goals met their deadline. Although considerable progress has been made towards the achievement of EFA and MDGs, evidence shows that none of these goals will be reached. In fact, if recent trends continue, the poorest girls will not have universal primary education before 2086. Globally, over 57 million children of primary school age (53% of them girls) and 69 million adolescents are still out of school, while 774 million adults, two-thirds of them women, remain illiterate. This means that EFA and MDGs remain an unfinished agenda.

Again during the year 2000, the ‘World Education Forum’ stressed the importance of viewing education as a fundamental human right ‘rooted in the legal and social environment as well as in the individual’s active resolve to enjoy his rights to the full’.

The State obligation providing basic education for all, undertaken at the World Education Forum must be viewed in the first place as part of the obligations under international law (pertaining to the right to education) as contained in international instruments, notably:

- Article 26 of the *Universal Declaration on Human Rights*,
- Articles 4 and 5 of the *Convention against Discrimination in Education* (1960),
- Articles 28-30 of the *Convention on the Rights of the Child*, and
- Articles 13 and 14 (right to education) of the *International Covenant on Economic, Social and Cultural Rights*.

The international covenants demonstrate an indisputable moral resolve to abide by the commitments assumed by those States and their partners when voicing their intention to adopt a given set of guidelines, as seen in the *World Declaration on Education for All* or the *Dakar Framework for Action*. The ethical basis and moral force of these declarations therefore needs to be recognized. *Universal Declaration of Human Rights* and the *Convention on the Rights of the Child*, that “all children, young people and adults have the human right to benefit from an education that will meet their basic learning needs in the best and fullest sense of the term, an education that includes learning to know, to do, to live together and to be”.

(II) The Indian state of elementary Education:

Elementary Education System in India is the second largest in the World with 1445807 schools located in 640 districts in 36 states. It imparts Elementary education to 197666909

students in India. In recent times India has made tremendous progress in literacy. As per Census 2011 the effective literacy rate has gone to 74.04% (for males 82.14 % and females 65.46 % per cent). The increase in literacy rate in males and females during 2001-2011 is in the order of 6.88 and 11.79 percentage points respectively. The gap of 21.59 percentage points recorded between male and female literacy rates in 2001 Census has reduced to 16.68 percentage points in 2011. Despite all these figures the trend is not very encouraging and needs attention. It's a pity that despite the entire toll claims the female literacy is still 65.46% during 2011 Census. Rajasthan ranks bottom 35 in all the states having 52.66% female literacy. The worst performing states in terms of female literacy are Rajasthan (52.66%), Bihar (53.33%), Jharkhand (56.21%), J&K (58.01%) and U.P (59.26%).

Constitutional commitment for elementary education: India being the signatory to Dakar declaration made elementary education a fundamental right by amending the Constitution (Eighty-sixth Amendment) during 2002. Act, 2002 to include Article 21A which states as under:

“21A. The State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine.”

The enforcement of RTE Act (April 2010) came after sustained popular mobilization by a wide range of civil society organizations and networks, including teachers' unions. The Indian Constitution now provides free and compulsory education for children between the ages of 6 and 14. It aims to bring out-of-school children into the formal education system, and there is a special effort to include children from disadvantaged groups and those with disabilities. The Act also focuses on improving the quality of teaching and learning. While these measures are noteworthy, another potentially controversial measure has also been advanced – support for public private partnerships (PPPs) in the delivery of education.

When this landmark RTE Act 2009 came into being a lot of hope emerged as the out of school children, child labour and those deprived of elementary education will be mainstreamed with Elementary Education. The Elementary education being the justiciable fundamental right was supposed to be the sole responsibility of the State. It's a pity that India is still having the world largest number of out of school children languishing the scourge of slavery; Child Labour, Bonded labour and other forms of deprivation. It will be worth mentioning that on 30 July 1992, in *Miss Mohini Jain vs. State of Karnataka & Ors*, 1992 SCR (3) 658, the Hon'ble Apex Court of India declared ;

“The right to education flows directly from right to life. The right to life under Article 21 and

the dignity of an individual cannot be assured unless it is accompanied by the right to education. The State Government is under an obligation to make endeavour to provide educational facilities at all levels to its citizens. The fundamental rights guaranteed under Part III of the Constitution of India including the right to freedom of speech and expression and other rights under Article 19 cannot be appreciated and fully enjoyed unless a citizen is educated and is conscious of his individualistic dignity.”

The 8 year Elementary Education in India: With more than 1448712 Elementary schools (354743 Private and 1093969 Govt) India operates the biggest education system in the world. It runs basic education called Elementary Education. In India elementary school, Class I – VIII is recognised as the period of compulsory schooling, with the constitutional amendment making education a fundamental right.

The elementary stage consists of a primary stage comprising Classes I-V followed by a middle stage of education comprising Classes VI -VIII. The recent notification of ‘Right of Children to Free and Compulsory Education Act 2009’ makes it compulsory 8 year schooling (1 to 8 grades) for all the children between the ages of 6 to 14. Thus now in India Elementary Education means universal schooling from class 1 to class 8th.

The progress of schooling system: The implementation of constitutional amendment and Right to Education Act 2009 is still sluggish and not all the children are in the schools. The DISE (District Information on School Education) data is a surprising report which reveals that the progress of elementary education is dubious and there is something inherently wrong in the enrolment of children. The ‘Right of Children to Free and Compulsory Education Act’ seems a far dream for all the children of this country.

Massive Number of Out of School Children!!!

Based on the 2011 Census figures, there were 233,583,108 children from age 6 to 14 in India. However, from the total enrolment figures for 2011-2012 (page 27 of the DISE 2012-13 Flash Statistics) had only 199,055,138 students in schools (“including enrolment in unrecognized schools and madrasas”). This means that over 34.5 Million children covered by the RTE Act were not enrolled in school.

Further, assuming population growth of 1.64% per year (the average between the 2001 and 2011 Census reports), there would be 237,420,972 children from age 6 to 14 in 2012. The DISE enrolment figures for 2012-13 show that only 199,710,349 students were enrolled in school. This is an increase to 37,710,623 students out of school, representing 15.9% of all children covered by the RTE Act. (Source PIL in Apex court of India by NCE)

These out of schools children don't come from affluent class. They are from poor, marginalized, displaced, deprivation victims, girls and minority children. Their hope of elementary education has been a far dream for decades. They will only be able to realize their right to education when state takes the plight of right based "Free and Compulsory Education" in the state run schools.

Number of children disappearing from Government schools: The DISE data 2013-14 is evident that unfortunately the enrolment in elementary schools (1 to 8) during the year 2013-14 has decreased. During the year 2012-13 there were 134,784,272 children studying in primary classes (1 to 5) which reduced to 132,428,440 children during 2013-14. Thus 2355832 children got reduced at lower primary level. Similarly at upper primary level (grade 6 to 8) there were 649,260,777 children during 2012-13 which increased to 664,712,19 during 2013-14. Hence the total number of students in elementary schools reduced from 199,710,349 (2012-13) to 198,899,659 during 2013-14. Thus the total number of students declined 810,690 during the academic year 2013-14). (A very substantial number???)

Just after the notification of the RTE Act 2009 during 2010-11 there were 134.421 million children in primary schools(1-5) which increased to 136.79 million in 2011-12 (adding+2.38 million),.In the following year 2012-13 this number decreased to 134.78 million(decrease of 2.00 million). During the year 2013-14 this number further decreased to 132.41million (Decrease of2.38 million).

However the surprising situation is shown in upper Primary schools where 574.48 Million children got increased during 2011-12 to 616.89 million (adding 4.24 Million). This number further increased to 649.26 Million (increase 3.24 Million) during 2012-13. Further during 2013-14 the enrolment increased to 655.49 Million (Increase 0.62 Millions).

During the academic year 2010-11 the total number of children (both in Govt and Private+ Unrecognized schools) at Elementary schools (1 to 8) were 191.85 Million. In the subsequent year this figure increased to 198.48 Million (Increase 6.26 Million). In the next year 2012-13 the total number of enrolled children increased to 199.70 Million (Increase 1.23 Million). Surprisingly during the following year 2013-14 the total enrolment decreased to 197.96 Million (Decrease 1.75 Million). See table (1).

It is a mysterious phenomenon as to how the total number of 2.38 million disappeared from our schools during 2013-14 at Primary level and overall (1 to 8) total 1.75 Million children disappeared from elementary schools. This is a big question and it raises a big

doubt either in the enrolment system or in governance of our schools. This definitely needs to be looked into.

Total number of children disappeared from our schools

Table (1)

Government + Private Total (No of children decreased/increased in brackets)			
Year	Grand Total (Govt + Pvt schools+ Unrecognized) (1-5)	Grand Total (Govt + Pvt schools+ Unrecognized) (6-8)	Grand Total elementary (Govt + Private +Un recognized schools) (1-8)
2010-11	134.41	574.48	191.85
2011-12	136.79 (+2.38)	616.89 (+4.24)	198.48 (+6.26)
1012-13	134.78(-2.00)	649.26 (+3.24)	199.70(+1.23)
2013-14	132.41(-2.38)	655.49(+0.62)	197.96 (-1.75)

Children increasing in Private schools: However, the enrolment has increased in private schools (see table 2 below), while has gone down in government schools. As shown below the enrolment in govt. primary school has gone down from 68.63 (2011-12) to 64.65% (2013-14) whereas in private schools in the same period it has increased from 31.37% to 35.46%. Similarly in Upper Primary govt. schools in the same period the enrolment has decreased from 62.17 % (2011-12) to 60.30 % (2013-14) as compared to private schools where it has increased from 37.83 % to 39.70%. Thus in elementary schools the total enrolment has gone down from 66.61 % (2011-12) to 63.13% (in govt. schools whereas in private schools it has gone up from 33.39% to 36.87%).

Per cent of children in Govt and private a comparison

Table (2)

Classes	Government School			Private School		
	2011-2012	2012-2013	2013-2014	2011-2012	2012-2013	2013-2014
Total Enrolment I to V	68.63	66.04	64.54	31.37	33.96	35.46
Total Enrolment VI to VIII	62.17	60.42	60.30	37.83	39.58	39.70
Total (I to VIII)	66.61	64.20	63.13	33.39	35.80	36.87

The declining trend in enrolment government schools and increasing trend in private schools is further evident in table (3). It is also worth mention that the unrecognized schools are also enrolling the children. However their enrolment is getting declined.

Table (3)

Grades	Govt schools		Private aided		Private un aided		Un recognized	
	2012-13	2013-14	2012-13	2013-14	2012-13	2013-14	2012-13	2013-14
Primary 1- 5	64.17	62.77	5.53	5.53	27.48	28.95	2.83	2.73
Upper Primary 6-8	59.40	58.43	13.99	12.97	24.92	25.49	1.68	1.72
Total Elementary 1-8	62.62	61.32	8.28	8.02	26.65	27.80	2.46	2.40

The trend of declining is continued: Right form the year 2010-11 (The year when the RTE Act was notified) the number of children in government primary schools gradually declined from 94.08 million (year 2010-11) to 91.65 million in 2011-12) then 86.49 million in 2012-13 and followed by 83.12 million during 2013-14. This is a shocking trend and shows the appalling state of government primary schools after enforcement of RTE Act 2009. (See table 3).

The Upper Primary schools show a gradual ascending order in enrolment i.e. in 2010-11 36 million which grew to 37.75 million in 2011-12 and 38.57 million in 2012-13 and 38.84 million in 2013-14. This again is a mystery as to how it is happening.

Surprisingly the total number of children enrolled in Govt Elementary schools (Primary + Upper Primary) schools during 2010-11 were 130.08 million which decreased to 129.40 in 2011-12, 129.40 million in 2012-13 and 125.06 during 2013-14. This declining trend of children in government schools is a worrisome situation and raises many questions on implementation of RTE Act 2009. See table (4)

(Table 4)

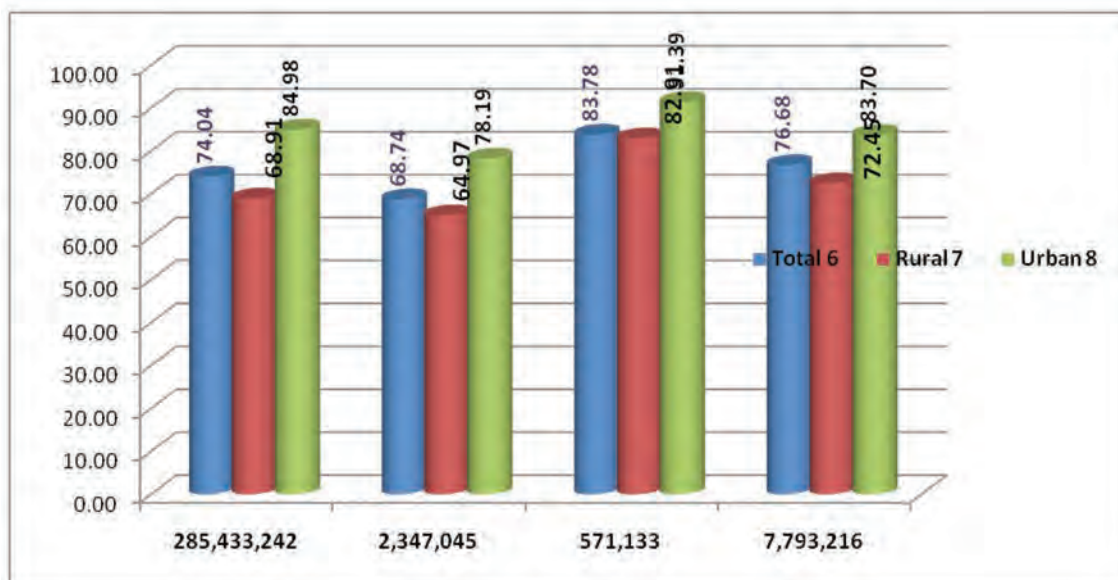
Year	Enrolment in Government Schools		
	Primary (1 to 5) in Millions	Upper Primary (6 to 8) in Millions	Total Elementary Govt (1 to 8) in Millions
2010-11	94.08	36.00	130.08

2011-12	91.65	37.75	129.40
2012-13	86.49	38.57	125.06
2013-14	83.12	38.84	121.96

Graph

Total No. of students enrolled

(Figures in millions)



Private schools; a mushrooming business: Despite of the fact that RTE Act makes certain norms and standards to be followed by private schools in terms of infrastructure, teachers and school governance it is hardly being followed and private schools are increasing in numbers. Also the government schools are having vacant position of teachers, poor governance and deployment of teachers in non-teaching activities results in Govt schools less attractive to parents. This is resulting in gradual increase of enrolment on private schools. As shown in (table 5)

(Table 5)

Year	Private Schools (Figures in millions)		
	Primary (1 to 5)	Upper Primary (6 to 8)	Total Elementary PVT (1 to 8)
2010-11	38.24	20.88	59.11
2011-12	41.90	22.97	64.86
1012-13	44.48	25.27	69.75
2013-14	45.67	25.57	71.23

Un-recognized schools: The DISE data (Flash Statistics 2013-14) shows the number of unrecognized schools. As shown in table no (5) the number of unrecognized schools is increasing despite the provision of enforcement of RTE Act 2009 which bans the unrecognized schools. A matter of fact the unrecognized schools have not been served any notice to become adherent to RTE norms. (See table 6)

Table (6)

Enrolment in Unrecognized (Figure in millions)		
Year	Primary (1-5)	Upper Primary(6-8)
2010-11	2.08	0.56
2011-12	3.24	0.98
1012-13	3.81	1.09
2013-14	3.62	1.14

(III) The justiciability of Right to education for marginalized communities and girl child:

The very objective of Education for all, Gender parity and justifiable right to education was meant to make sure that backward communities, scheduled Castes, Scheduled Tribes and minorities (specially Muslims) will be able to mainstream in the 8 year elementary schooling system. Let us see the progress towards this area;

Muslims: As far as the Muslim community children are concerned the progress seems to be by an large on the track. The enrolment of both boys and girls in Primary level (1 – 5) from 2010-11 to 2013-14 has been in increasing order. However in case of Muslim girls the enrolment decreased from 49.22% (2012-13) to 49.12 % (2013-14). In Upper

Primary level also the combined enrolment of both boys and girls have been in increasing order during the same period. Again in case of girls the enrolment decreased from 51.48% (2012-13) to 51.38% (2013-14). The total elementary level (1 to 8) the enrolment of girls has decreased from 49.88% (2012-13) to 49.81% (2013-14) (see table (7)).

Table (7)

Muslims

	Primary 1 to 5		U Primary		Elementary(1-8)	
	Enrolment of Muslims %		Enrolment of Muslim %		Enrolment of Muslim %	
Year	Total boys+ girls	Girls	Total boys+ girls	Girls	Total boys +girls	Girls
2010-11	13.04	49.06	11.25	48.71	12.5	49.56
2011-12	13.31	49.17	11.65	51.31	12.79	49.78
2012-13	14.20	49.22	12.11	51.48	13.52	49.88
2013-14	14.34	49.12	12.52	51.38	13.73	49.81

(B) Other Backward Communities (OBC): The OBC girls too have the same story. As shown in table No.(8) the enrolment of girls has decreased from 48.65% (2012-13 to 48.49% (2013-14). In Upper Primary level also the trend is the same .During the same period the girl's enrolment has decreased from 48.92% to 48.81%. The overall enrolment of OBC girls at elementary school (1 to 8) during the same period has decreased from 48.74% to 48.59%. This shows how the RTE Act needs to take more serious steps to ensure the girls enrolment in particularly in OBCE communities.

Table (8)

OBC

Year	Primary 1 to 5		U Primary		Elementary(1-8)	
	Enrolment of OBC %		Enrolment of OBC%		Enrolment of OBC%	
	Total boys+ girls	Girls	Total boys + girls	Girls	Total boys+ girls	Girls
2010-11	40.09	48.63	40.27	48.26	40.14	48.52
2011-12	42.80	48.54	43.25	48.61	42.94	48.56
2012-13	42.91	48.65	43.66	48.92	43.15	48.74
2013-14	44.10	48.49	44.44	48.81	44.21	48.59

Schedules Tribes:

The enrolment of Schedules Tribes children is most worrisome; The RTE Act has not been able to encourage ST children in schools much. The combined enrolment (boys and girls) has shown decreasing order from 2011-12 11.40% to 11.31% in following year and 11.09% in 2013-13. The ST girls enrolment too has been in decreasing order from 48.54% (2012-13) to 48.34% in following year. In Upper Primary level also the combined enrollment (boys +Girls) is in decreasing order from 9.86% 2011-12 to 9.75% in following year and 9.73% in 2013-14. The overall enrolment of ST boys and girls at Elementary schools (1-8) has decreased from 10.92 (2011-12 to 10.85% in next year and has further gone down to 10.63% in the following year. The girls situation is again the same. The elementary enrolment of girls has decreased from 48.67% (2012-13 to 48.46% during 2013-14.(See

Table (9)

Scheduled Tribes

Year	Primary 1 to 5		U Primary		Elementary (1-8)	
	Enrolment of ST %		Enrolment of ST %		Enrolment of ST %	
	Total boys+girls	Girls	Total boys+girls	Girls	Total boys+girls	Girls
2010-11	11.26	48.53	9.41	48.16	10.7	48.43
2011-12	11.40	48.49	9.86	48.66	10.92	48.54
2012-13	11.31	48.54	9.75	49.03	10.85	48.67
2013-14	11.09	48.34	9.73	48.73	10.63	48.46

(D) Scheduled Castes: The Schedules Castes are no exception to this phenomenon. The SC girls enrolment at primary level has decreased from 48.52% (2012-13 to 48.31% 2013-14. At Upper Primary level also this situation is applicable to both boys and girls as the enrolment of boys and girls at U Primary level has decreased from 19.47% (2012-13 to 19.41% in the following year. The girls enrolment too has dropped from 48.95% to 48.76% in the same period at Upper Primary level. Also the overall enrolment of Elementary schools (1 -8) shows the SC enrolment (both boys and girls) has gone down from 20.24% (2012-13) to 19.72% in the following year. The girls enrolment again has dropped from 48.50% 2010-11 to 48.49% in the following year and has further dropped to 48.64% in the next year. This trend further goes by decreasing the SC girls enrolment to 48.46% during 2013-14.

Table (10)
Scheduled Caste

	Primary 1 to 5		U Primary		Elementary (1-8)	
	Enrolment of SC %		Enrolment of SC %		Enrolment of SC %	
Year	Total boys+girls	Girls	Total boys+girls	Girls	Total boys+girls	Girls
2010-11	19.06	48.50	18.42	48.50	19.06	48.50
2011-12	19.80	48.42	19.14	48.64	19.80	48.49
2012-13	20.24	48.52	19.47	48.95	20.24	48.64
2013-14	19.88	48.31	19.41	48.76	19.72	48.46

The overall situation is self-explanatory the benefits of RTE Act has not so far been reached to the desired level to marginalized communities, minorities, SC ST Etc. The girls are seen to be most neglected in the entire phenomenon.

The appalling state of children in difficult situation:

As per the Census 2011 the total number of children as main workers enumerated were 17703310 out of which 1108808 were between the age group of 5 to 9 where as 3244439 were in 10 to 14 years age. This is the age group for realization of fundamental right of education for all the children of India. Table 11 further shows that as much as 9458107 children were engaged as economically active children

(Main and marginal) . why is this situation? Whose children are they?

Table (11)
Children as main and marginal workers in 2011 Census

State / UT	Age-Group	Main workers	Marginal workers	
			< 3 months	3-6 months
Children	5-9	1108808	357920	1066910
	10-14	3244439	1542262	2808324
	15-19	17703310	3054963	9458107

Unfortunately the identification of children in the age group of 6 to 14 is the responsibility of local authority. It is mandated in the RTE Act that all the children in the age group of n6 to 14 shall be enumerated and maintained in the public domain. The school planning

should be done in accordance of these children. Unfortunately this is not happening and still such children are languishing the scourge of child labour and slavery.

IV. The Enforcement of Right of Children to Free and Compulsory Education Act 2009.

On 18.8.2015 the hon'ble High Court of Allahabad in disposing a series of writ petitions directed the UP Government as under:

It is the lack of accountability and casual approach on the part of officials of Basic Education Department that mindless, negligent, casual amendments in Rules; defective Government Orders have been issued from time to time creating cause for multifarious litigations resulting not only in delay in appointment of Primary Teachers but also a very heavy pressure on this Court also.

90. Therefore, the Chief Secretary, U.P. Government is directed to take appropriate action in the matter in consultation with other Officials, responsible in this regard, to ensure that the children/wards of Government servants, semi-Government servants, local bodies, representatives of people, judiciary and all such persons who receive any perk, benefit or salary etc. from State exchequer or public fund, send their child/children/wards who are in age of receiving primary education, to Primary Schools run by Board. He shall also ensure to make penal provisions for those who violate this condition; for example, if a child is sent to a Primary School not maintained by Board, the amount of fee etc. paid in such privately managed Primary School, an equal amount shall be deposited in the Government funds, every month, so long as such education in other kind of Primary School is continued. This amount collected can be utilised for betterment of schools of Board.

Besides, such person, if in service, should also be made to suffer other benefits like increment, promotional avenues for certain period, as the case may be. This is only illustrative. The appropriate provisions can be made by Government so as to ensure that ward(s)/child/children of persons, as detailed above, are compelled necessarily to receive primary education in the

Primary Schools run by Board.

Part of direction from Allahabad High Court direction to UP Govt.

This was viewed as one of the most historic direction in favour of children right to education.

Unfortunately Uttar Pradesh Government who was supposed to comply with this direction is moving to hon'ble Apex Court for quashing this direction. This clearly shows the political will of the state. The situation is same in most of the states of India.

Due to violations of noncompliance of the RTE Act by the states a petition has been filed by National Coalition for Education (NCE) as public interest litigation under Article 32 directly in this Hon'ble Supreme Court of India. However the apex court has asked the petitioner to file PIL in the states as the states are mandated to enforce and implement the RTE Act 2009. The state governments were supposed to fully implement the RTE Act by notifying and making necessary infrastructural and managerial arrangements by March 2013. This was to ensure that universalization of elementary education is achieved.

The roadmap for universalising elementary education was derived from the definite timeframes mandated in the RTE Act; it prescribes a timeframe of three years for the establishment of neighbourhood schools, provision of school infrastructure with an all-weather building and basic facilities, and provision of teachers as per prescribed Pupil–Teacher Ratio (PTR) (30:1). Further, the RTE Act stipulates that all untrained teachers in the system must be trained within a period of five years from the date of enforcement of the Act.

The rest of the provisions were required to be implemented with immediate effect. The RTE Act has had considerable implications for the overall approach and implementation strategies of on-going programme of SSA. With the enactment of the RTE, SSA norms were needed to review and align with the RTE mandate.

The Implementation Framework of RTE Act, 2009: following provisions;

Table 1

SN	Activity	Timeframe
1	Establishment of neighbourhood schools <ul style="list-style-type: none"> • Provision of school infrastructure • All-weather school buildings • One-classroom-one-teacher • Office-cum-store-cum-head teacher room 	3 years (by 31 March 2013)

2	Toilets and drinking water facilities <ul style="list-style-type: none"> • Barrier-free access • Library • Playground • Fences/boundary walls 	3 years (by 31 March 2013)
3	Provision of teachers as per prescribed PTR	3 years (by 31 March 2013)
4	Training of untrained teachers	5 years (by 31 March 2015)

Source: GoI (2009, 2012).

1. The status of implementation of RTE Act in India: Our observation

The recent notification of ‘Right of Children to Free and Compulsory Education Act 2009’ makes it compulsory 8 year schooling (1 to 8 grades) for all the children between the ages of 6 to 14. Thus now in India Elementary Education means universal schooling from class 1 to class 8th for every child a justifiable fundamental right.

1.1 The 8 year Elementary Education in India: With more than **1448712** Elementary schools (**319990** Private and **1093969** Govt) India operates the biggest education system in the world. It runs basic education called elementary education. In India elementary school, Class I – VIII is recognised as the period of compulsory schooling, with the constitutional amendment making education a fundamental right. In India the elementary stage consists of a primary stage comprising Classes I-V, followed by a middle stage of education comprising Classes VI –VIII. The minimum age for admission to Class I of the primary school is generally 5+ or 6+.

1.2 The progress of schooling system: The implementation of constitutional amendment and Right to Education Act 2009 is still sluggish and not all the children are in the schools. The DISE (District Information on School Education) data is a surprising report which reveals that the progress of elementary education is dubious and there is something inherently wrong in the enrolment of children. The ‘Right of Children to Free and Compulsory Education Act’ seems a far dream for all the children of this country.

1.3 Massive Number of Out of School Children!!!

The ground reality: Based on the 2011 Census figures, there were 233,583,108 children from age 6 to 14 in India. However, from the total enrolment figures for 2011-2012 (page 27 of the DISE 2012-13 Flash Statistics) had only 199,055,138 students in schools (“including enrolment in unrecognized schools and madrasas”). This means that over 34.5 Million children covered by the RTE Act were not enrolled in school.

Further, assuming population growth of 1.64% per year (the average between the 2001 and 2011 Census reports), there would be 237,420,972 children from age 6 to 14 in 2012. The DISE enrolment figures for 2012-13 show that only 199,710,349 students were enrolled in school. This is an increase to 37,710,623 students out of school, representing 15.9% of all children covered by the RTE Act. (Source NCE)

These out of schools children don't come from affluent class. They are from poor, marginalized, displaced, deprivation victims, girls and minority children. Their hope of elementary education has been a far dream for decades. They will only be able to realize their right to education when state takes the plight of right based “Free and Compulsory Education” in the state run schools.

1.4 Children economically active/Child Labour

The ground reality: According to RGI Census 2011 there are still 9188375 children working as child labour (Main+ marginal workers). Apart from this there are 111946736 adolescent workers in the age group of 15 to 19 (Juvenile children who are supposed to be in the schools. Definitely these children have been denied the right to education. According to this data a sum of 9188375 children were currently out of school as child labour. Apart from these figure 6501739 children between 15 to 19 were engaged as main workers, 90310069 as less than 3 month workers and 15134928 were working for 3 to 6 months .Our clear interpretation is that these children should have been enrolled in the schools during 2010 when the RTE Act was enacted. Because they were denied the right to education during this period they ought to have been admitted in age specific schools to complete their right to education. This is very serious lapse of our RTE implementation.

See table 2.

Table 2

Census 2011 Main and marginal workers in childhood

SN	Total child main workers	4353247
1	less than 3 month working	959894
2	3 to 6 month working	3875234
	Total child labour	9188375
1	15 to 19 main	6501739
2	,, less than 3 month	90310069
3	3 to 6 month working	15134928
	Total Adolescent working	105444997

1,5 (Part IV) section 9 Responsibilities of the appropriate Government and local authority (*Explanation: For the purpose of determining and for establishing neighbourhood schools, the appropriate government of the local authority shall undertake school mapping, and identify all children, including children in remote areas, children with disability, children belonging to disadvantaged groups, children belonging to weaker section and children referred to in section 4 within a period of one year from the appointed date, and every year thereafter.*)

1.6 School mapping:**Duties of State Government and Local Authority for the purposes of Sections 8 and 9**

5. (1) (2) *For the purpose of determining and for establishing neighbourhood schools, the State government/local authority shall undertake school mapping, and identify all children, including children in remote areas, children with disabilities, children belonging to disadvantaged groups, children belonging to weaker sections and children referred to in section 4, within a period of one year from the appointed date, and every year thereafter.*

The ground reality: It's a pity that in almost all the states the school mapping exercise has not been done by appropriate government or the local authority. This has rather been shifted to school teachers. The school teachers were not supposed to conduct school mapping. In most of the cases school teachers have been instructed to conduct 'household survey' without the participation of SMC or local authority. This has resulted in missing out almost all the child labour, migrant labours and children of weaker sections, begging children, street children. Such children are not supposed to be identified in household survey, as they don't live in so called 'houses'. This is a serious lapse leaving the children from the right to education.

1.7 Chapter IV Section 27: Prohibition of deployment of teachers for non-educational purposes.

No teacher shall be deployed for any non-educational purposes other than the decennial population census, disaster relief or duties relating to elections to the local authority or state legislature or Parliament, as the case may be.

The ground reality: We have examples from Punjab, Chandigarh and other states where teachers are being deployed for more than five years duration in govt offices for non-academic duties (as they are supposed to do only census, election duty and disaster relief work)

1.8 Part II School Management Committee

Section 3 Composition and function of the School Management Committee;

The said committee shall... perform the following functions, namely; © Monitor that teachers are not burdened with non-academic duties other than those specified in section 27.

The ground reality: Unfortunately the SMC has neither been trained on these issues nor any exercise has been encouraged where they can have a say.

1.9 PART III – DUTIES OF STATE GOVERNMENT, LOCAL AUTHORITY

Areas or limits for the purposes of section 6

4 (1) *The areas or limits of neighbourhood within which a school has to be established by the State Government shall be as under -*

(a) *In respect of children in classes I - V, a school shall be established within a walking distance of one km of the neighbourhood.*

(b) *In respect of children in classes VI - VIII, a school shall be established within a walking distance of 3 km of the neighbourhood.*

(2) *Wherever required, the State Government shall upgrade existing schools with classes I - V to include classes VI – VIII. In respect of schools which start from class VI onwards, the State Government shall endeavour to add classes I – V, wherever required.*

(6) *The Local Authority shall identify the neighbourhood school(s) where children can be admitted and make such information public for each habitation within its jurisdiction.*

The ground reality: It is agonizing to note that a huge no of schools has either been closed or merged with other schools in many states. This makes the availability of primary schools a problem for children (within 1 km limit) and Upper primary school

within 3 km limit. This is a clear violation of RTE Act 2009. Following table gives the information of the states where schools have either been closed or merged:

1	Rajasthan	17129
2	Gujrat	13450
3	Maharashtra	13905
4	Karnatka	12000
5	Andhra Pradesh	5503
6	Odisha	5000
7	Telangana	4000
8	Madhya Pradesh	3500
9	Tamil Nadu	3000
10	Uttarakhand	1200
11	Punjab	1170

Source : various publications, paper cuttings

Maintenance of record of school aged children:

(3) The record, referred to in sub-Rule (1), shall be maintained transparently, in the public domain, and used for the purposes of clause (e) of section 9

(4) The record, referred to in sub-Rule (1) shall, in respect of every child, include

(a) name, sex, date of birth, (Birth Certificate Number), place of birth;

(b) parents' / guardians' names, address, occupation;

(c) pre-primary school/Anganwadi centre that the child attends (upto age 6);

(d) Elementary school where the child is admitted;

(e) Present address of the child;

(f) Class in which the child is studying (for children between age 6-14), and if education is discontinued in the territorial jurisdiction of the Local Authority, the cause of such discontinuance;

(g) whether the child belongs to the weaker section within the meaning of clause (e) of section 2 of the Act;

(h) whether the child belongs to a disadvantaged group within the meaning of clause

(d) of section 2 of the Act;

(i) details of children requiring special facilities / residential facilities on account of migration and sparse population; age appropriate admission; disability.

(5) The Local authority shall ensure that the names of all children enrolled in the schools under its jurisdiction are publicly displayed in each school.

The ground reality: It's a pity that this practice is not being observed in the schools. Neither the bank account of SMCs are operational not the school grants are being channelized through this system

1.10 Section 4 Preparation of School Development Plan;

Preparation of School Development Plan for the purpose of section 22

14. (1) The School Management Committee shall prepare a School Development Plan at least three months before the end of the financial year in which it is first constituted under the Act.

(2) The School Development Plan shall be a three year plan comprising three annual sub Plans.

(3) The School Development Plan should be signed by the Chairperson/Vice-Chairperson and Convener of the School Management Committee and submitted to the local authority before the end of the financial year in which it is to be prepared.

The ground reality: Unfortunately in most of the states the SMCs have been formed but bank accounts are not yet opened. Where opened the operation is not being made through these bank as prescribed in the law. Also the SDP is still not being prepared by SMC members and no hand holding exercise is in place. Also where SDP is prepared is not honoured by the department.

1.11 Section 15 Recognition to School

Recognition of schools for the purposes of section 18

11 (1) Every school, other than a school established, owned or controlled by the State Government or Local Authority, established before the commencement of this Act shall make a self-declaration within a period of three months of the commencement of the Act, in Form No. 1 to the concerned District Education Officer regarding its compliance or otherwise with the norms and standards prescribed in the Schedule and the following conditions:.....

(5) Any person who continues to run a school the recognition is withdrawn. Shall be liable to fine which may extend to one lakh rupees and in case of continuing contraventions, to a fine often thousand rupees for each day during which such contravention continues.”

1.12 Section 16 Withdrawal of recognition to school

Withdrawal of recognition to schools for the purposes of sections 18(3) and 12(3) 12

(1) Where the District Education Officer on his own motion, or on any representation received from any person, has reason to believe, to be recorded in writing, that a school recognized under rule 12, has violated one or more of the conditions for grant of recognition or has failed to fulfill the norms and standards prescribed in the Schedule, he shall act in the following manner:

(a) Issue a notice to the school specifying the violations of the condition of grant of recognition and seek its explanation within one month.....

The District Education Officer shall, on the basis of the decision of the State Education Department, pass an order cancelling the recognition granted to the school. The order of de-recognition shall be operative from the immediately succeeding academic year and shall specify the neighbourhood schools to which the children of the de-recognised schools shall be admitted.

The ground reality: Unfortunately the unrecognized schools are still running scot-free and neither notices have been served to them nor have they applied for getting recognition as per RTE Norms. In fact school mapping was supposed to take care of this anomaly which has not happened.

1.13 Section 12 (C) of the Right of Children to Free and Compulsory Education Act 2009 (RTE Act) provides reservation of 25% of seats for economically weaker section (EWS) children in private schools at entry level.

The ground reality: In most of the states of India this provision is being grossly violated. Either children are not admitted or if somewhat admitted are segregated in the classroom with elite class students. (For example in Uttar Pradesh 30.71% (73656 schools) is providing elementary education. According to a rough estimate this provision provides more than 7,00,000 seats, available for EWS children out of which only 60 seats are filled on the verge of completion of five years of RTE enactment. The other states are no different from UP example.

The overall situation explained in above paragraphs show that the achievement of Education for all in India is still a distant dream. The state was supposed to open new schools, fill the vacant position of 1.5 million teachers, regulate the unregulated private schools and identify the children in difficult situations.

(V) Spending on Education after RTE Act enforcement:

During 2013, India ranked 136th in Human Development Index (HDI) among 186 countries in the world in the Human Development Report released by UNDP. Currently, the education and health indicators in India fare poorly in comparison to other developing countries. Undoubtedly, in the last five decades, school enrolments have increased, more adults are declared (functionally) literate than ever before; girls in both rural and urban areas have now greater access to education.

The history of universalizing education across the world clearly indicates that governmental spending led to the universalization. By 1900 universalization was nearly complete in OECD / developing countries with governmental funding support. Similarly, even developing countries such as South Korea, Malaysia who are seen as high achievers have much higher public spending on health and education which has resulted in human development comparable to the industrialized world.

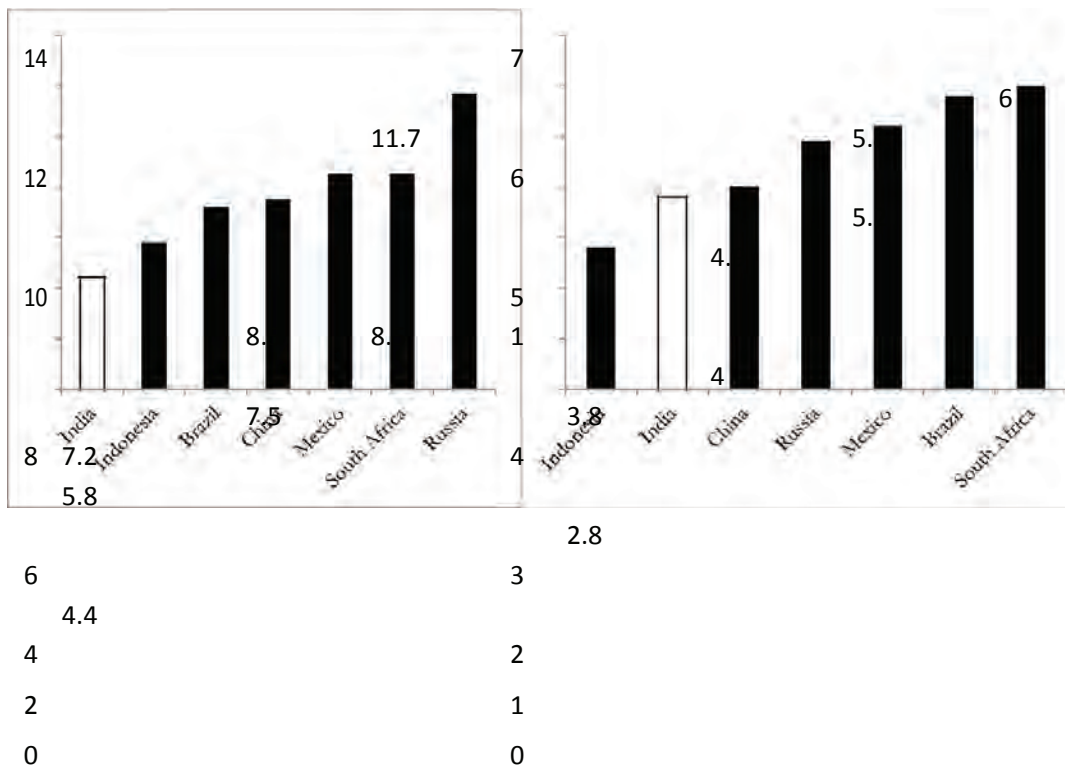
At this point in time, there is a view that since the largest allocations in the recent five year plan have been to education and health, cutbacks will also need to be done in these sectors. Also, in universalization of secondary education, there will be a huge initial requirement for physical infrastructure. Let us see the budgetary provisions on education in current budget;

- A marginal increase in allocation for elementary, secondary and higher education compared to 2013-14(BE) and 2014-15(interim budget)
- Share of education in total budgetary allocation for 2014-15 has decreased from 2012-13 and 2013-14 expenditure
- After three years of 12th Five Year Plan (FYP), allocation for SSA, MDM, RMSA are much lower than proposed outlay recommended in 12 FYP
- No intervention to improve shortage of human resources in education sector

Since the financial year 2004-04 (UPA Govt) government of India decided to become self reliant on social spending specially on education. Hence it gradually stopped the ODA from other countries. In also introduced “Education Cess 2% for elementary Education +1% on Higher Education. Since then more than 50% of elementary Education budget is met from “Cess”. (See chart 1.4.1) But, despite arrangement, India has failed to produce an appreciable progress report in the education sector. Expansion of education in India has been remarkably slow as compared to BRIICSAM countries (Brazil, Russia, India, Indonesia, China, South Africa and Mexico) in terms of adult education as well as Government spending on education (Chart 1.1 & 1.2). As per UNDP’s data (2012), India

records a meagre 4.4 mean years of education received by people aged 25 and above, which is much less than rest of the BRIICSAM countries. The public spending on education is one of the lowest among BRIICSAM countries. Brazil, one of the examples of achieving universal education spends six percent of GDP in education, whereas India spends less than four percent on it.

Chart 1.1 Mean Years of Education Received Chart 1.2 Public Spending on Education as Share of GDP (in Percent) by People Aged 25 and Above

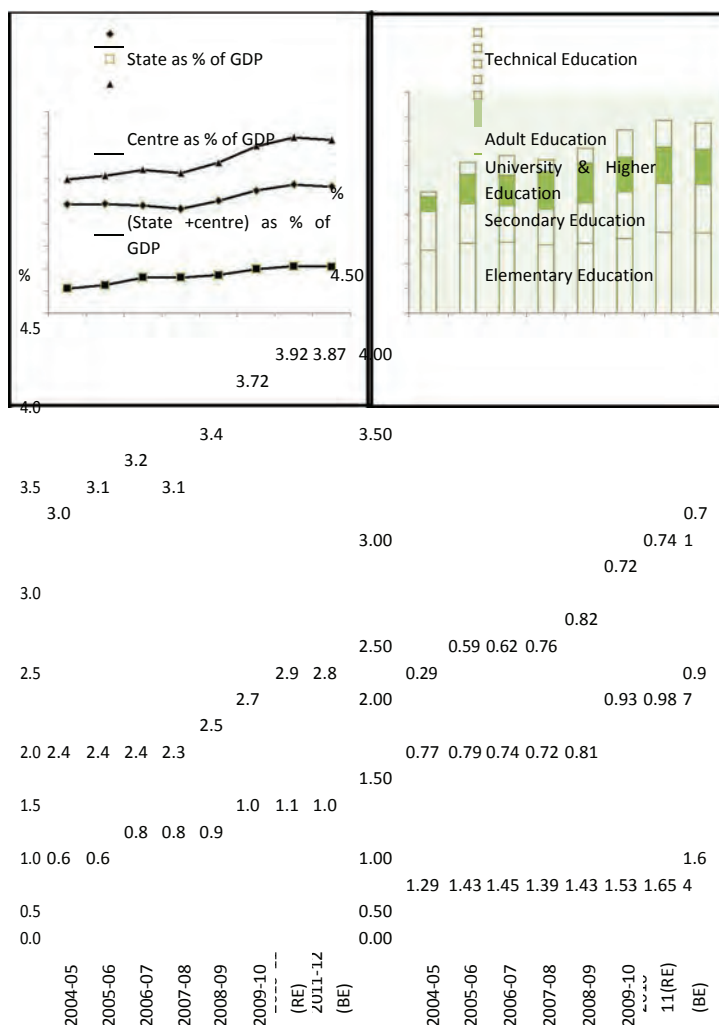


Source: UNDP open data portal (<https://data.undp.org>)

Provisioning of education, both for its coverage as well as quality, requires significant amount of financial resources. The BJP election manifesto mentions that **education needs an urgent solution** and as one of the measures, **public spending on education would be raised to 6% of the GDP, and involving the private sector would further enhance this.**

Public Expenditure on Education: The pattern of Central and State Government expenditure in a particular sector reflects the priority for the sector in the overall policy paradigm in the country. In 1966, the Kothari Commission had recommended that public spending on education in India should be raised to the level of 6 percent of Gross National Product (GNP) by 1986. Subsequently, many references have been made to the need for stepping up total public spending on education in India to the level of 6 percent of GDP. However, the situation in this regard still remains a cause for serious concern.

Chart 1.3 Composition of Public Expenditure on Education as Percent of GDP



Note: GDP figures are at current market price; Source: Analysis of Budgeted Expenditure on Education 2009-10 to 2011-12, Planning and Monitoring Unit, Department of Higher Education, MHRD (2013); GDP figures are from National Account Statistics, 2014, CSO

India's Combined Public Expenditure (Centre plus States) on Education, as a proportion of GDP, was around 3.0 percent in the year 2004-05. It has increased over the last decade, but at a very modest pace. The present level of combined public spending on education (of not just Education Departments at the Centre and in the States but also the other departments that spend on education) works out to 3.72 percent of the GDP (in 2009-10). Even this proportion falls much short of the 6 percent of GDP for education, recommended in 1966 by the Kothari Commission. The sectoral break up shows major share of allocation goes for elementary education; though overtime a marginal improvement in allocation is observed in elementary and secondary level of education, however, 2008-09 onwards, allocation for University and higher education has gone down and continuously decreasing in the following years.

Over the last ten years, from 2004-05 to 2014-15 (BE), Union Government's spending on education as a proportion of total Union Budget has increased by 2 percentage points only (Chart 1.4). However, a marginal decrease in share is observed in 2014-15 allocations as compared to 2012-13 and 2013-14(RE). The combined expenditure on education by Union and State Government shows that States accounts for a much larger share in the country's total budgetary spending on education as compared to Union Government. Though education is the responsibility of both Union and the State (as in concurrent list), but Union government having a larger scope for augmenting revenues, should take a larger responsibility towards provisioning of financial resources for education.

Financing Right to Education (RTE)

There is clear consensus that improved education holds the key to India's future and the passage of the RTE stands testimony to this. *The Right of the Children to Free and Compulsory Education Act, 2009* came into effect from April 1, 2010, with an objective to ensure quality elementary education to every child in India. The RTE Act lays out a clear five year time period to reach its provision. On the eve of last year of RTE time line, it is high time to take a relook at how the implementation of the scheme has been carried out. Union Government has mandated SSA as the main vehicle through which the Union and State Governments are carrying out their measures for implementing the provisions of this legislation across the country. The 12th Plan has recommended an allocation of Rs. 1,92,726 crore for SSA (for the Plan period) from the Union Budget, which amounts to Rs. 38,545 crore per year. Against this, the budgetary allocations for SSA by the Union Government for 2012-13,

2013-14 and 2014-15 have seen shortfalls of Rs. 12990 crore, Rs. 11287 crore and Rs. 10287 crore respectively (Table 1.2).

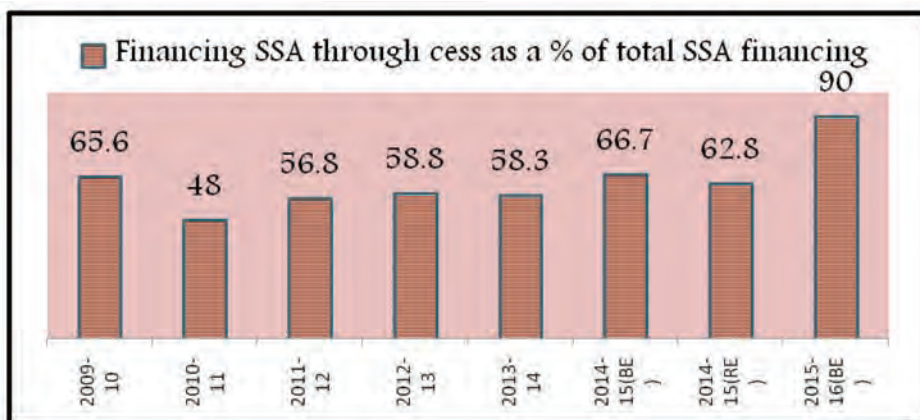
Table 1.2: Union Govt. Allocation and Expenditure under SSA (Figures in Rs. Crore)

	2012-13	2013-14 (RE)	2014-15(BE)
Allocation (BE) for SSA	25555	27258	28258
Expenditure (actual) under SSA	23873.4	26608	-
Shortfall of allocation compared to proposed allocation	12,990	11,287	10,287
Shortfall of expenditure compared to proposed allocation	14,672	11,937	-

Note: BE- Budgetary Estimate, RE-Revised Estimate; Source: Expenditure Budget, Vol II, MHRD, Various years

1.4.1 Financing RTE through Cess:

Chart 1.4



As shown in chart 1.4 the spending on Elementary Education is almost dependent on “Education Cess”

The Department of Elementary Education and Literacy receives the proceeds from the cess, which the Union Government levies on all central taxes and maintains under a non-lapsable fund called the Prarambhik Shiksha Kosh (Fund created at Union Government level to finance elementary education).

While the contribution of Education “Cess” was primarily meant to fulfill the gap in government’s contribution as additional amount, however it grew to be more of a substitute. After a check in 2010-11, the subsequent years observed a continuous increase in the share of *Prarambhik Shiksha Kosh* as part of the Union Government’s financing of RTE. In 2015-16(BE), about 90 percent of the SSA financing has been planned through education Cess. (Chart 1.4).

Though there is an improvement in SSA allocation for education over the years, the problems in utilisation of funds allocated for SSA and other schemes in education have been a matter of serious concern. As reported by MHRD, nearly 25% of the funds allocated by the Union and State Governments for SSA remain unutilized. The shortage of human resources in education sector as recognized by MHRD is one of the major reasons for under-utilization of fund (Economic Survey, 2013-14). However, this issue was neither addressed in the Budget Speech and nor reflects in the budgetary allocation. This shows apathetic political will towards millions of children out of schools and other marginalized sections of society whose children are languishing the scourge of child labour, street children and domestic labour. For them the “Right to education” still seems a distant dream.

Now the Government has shown interest in inviting private sector in education in the name of Public Private Partnership is a big question mark on the issue of universalization of elementary education. The budget required for universalization of Elementary education is not available in an economy of India’s size needs to be questioned. The entry of large corporate actors would compound the nature and extent of corrupt practices and lead to new bureaucratic contractor nexus creation.

Since the very inception the investment in public education has been much lower than what government appointed ‘Kothari Commission’ sought for during 1968. The shortages in these investments have a cumulative effect and with each year, the backlog of investment required increases. Much higher investments in teacher education and education administration institutions are needed. The DIET, BRC, CRC system which is expected to provide academic monitoring and support across the entire country, needs much greater investment, both in professional capacities and in autonomy and accountability mechanisms.

(VI) The way forward: The Education 2030 and SDG Goal (4)

The Education for All (EFA) a global commitment:

EDUCATION FOR ALL (EFA) has already completed its 15 year promised deadline in the year 2015 with incredible achievements on six goals throughout the world. It also left with many unfinished goals by many countries including India. On 21 May 2015, the Incheon Declaration was adopted at the World Education Forum 2015 (WEF 2015) by 120 ministers, heads and members of Government delegations from 160 countries and development partners.

The Incheon Declaration reaffirms the vision of the worldwide movement for Education for All (EFA), initiated in Jomtien in 1990 and reiterated in Dakar in 2000. Countries and the global education community committed to a single, renewed education agenda that is holistic, ambitious and aspirational, and leaves no-one behind. This new education agenda, 'Education 2030' is fully captured in the Sustainable Development Goal 4 (SDG 4) and its corresponding targets which aims to, "Ensure inclusive and equitable quality education and promote life-long learning opportunities for all". The Declaration represents a collective commitment of the education community to implement the Education 2030 agenda. It affirms the principles of education as a public good, as a fundamental human right, as a basis for guaranteeing the realization of other rights, and inspires bold and innovative action.

On 25 September 2015, 2030 Agenda for 'Sustainable Development' was formally adopted at the 70th United Nations General Assembly in New York City. At the gist of this new agenda lie the 17 **Sustainable Development Goals (SDGs)** which include SDG 4 on education that succeed the Millennium Development Goals (MDGs). Following the adoption of the SDGs, the Framework for Action Education 2030: Towards inclusive and equitable quality education and lifelong learning for all will be adopted at a high-level meeting at the 38th session of the General Conference of UNESCO in November 2015. The Education 2030 Framework for Action (FFA) serves as the overall guiding framework for the implementation of Education 2030 and outlines how to translate the global commitment into practice at the global, regional and national levels. It aims to support all countries to realize their own vision and ambitions for education within the framework of SDG 4 and its targets and proposes ways of implementing, coordinating, financing and monitoring Education 2030 to ensure equal education opportunities for all.

Fundamental principles of Incheon declaration:

The principles informing this Framework are drawn from international agreements, including Article 26 of the Declaration of Human Rights, the Convention against Discrimination in Education, the Convention of the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Elimination of All Forms of Discrimination against Women.

- **Education is a fundamental human right and an enabling right.**

To fulfill this right, countries must ensure universal access to inclusive and equitable quality education and learning, which should be **free and compulsory**. Education shall be compulsory and free at the primary education level, and progressively free at the secondary and higher education levels. Education shall aim at the full development of the human personality and promote understanding, tolerance, friendship and peace.

- Education is a public good, of which the State is the duty bearer. Education is a shared societal endeavour, which implies an inclusive process of public policy formulation and implementation. Civil society, teachers, the private sector, communities, families, youth and children all have important roles in realizing the right to quality education. The role of the State is essential in regulating standards and norms.^x
- **Gender equality** is inextricably linked to the right to education for all. Achieving gender equality requires a rights-based approach that ensures that female and male learners both not only gain access to and complete education cycles, but are empowered equally in and through education.

GOAL, TARGETS AND INDICATORS

Overarching goal

“Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all”

The overarching Sustainable Development Goal for education expresses the new key features of Education 2030, which underpin this Framework for Action:

Ensure **access** to quality education for all children and youth to at least 12 years of publicly-funded primary and secondary schooling, of which at least 9 years should be compulsory and free as well as access to quality non-formal education for out-of-school children and the

provision of learning opportunities to develop functional literacy and numeracy for youth and adults and foster their full participation as active citizens. Provision of at least one year of free and compulsory quality pre-primary education should also be ensured.

Ensure **equity and inclusion** so that everyone has an equal opportunity to obtain access to education and to learn. Therefore this agenda pays particular attention to vulnerable groups who are disadvantaged by factors such as gender, poverty, conflict or disaster, geographical location, ethnicity, language, age or disability.

An integral part of the right to education is ensuring that education is of **good quality** and leads to relevant and effective learning outcomes at all levels and in all settings. Good quality education necessitates, at a minimum, that learners develop foundational literacy and numeracy skills as building blocks for further learning as well as higher-order skills. This requires the development of relevant teaching and learning methods and content that meets the needs of all learners taught by well-qualified, adequately paid and motivated teachers using appropriate pedagogical approaches, as well as the creation of safe, healthy, gender-responsive, inclusive and adequately resourced environments that encourage and facilitate learning.

The right to education begins at birth and continues throughout life; therefore the concept of **lifelong learning**^{xi} guides Education 2030. Beyond formal schooling, flexible lifelong and broad learning opportunities should be provided through non-formal pathways and through stimulating informal learning.

Conclusion and Recommendations:

As explained in foregoing pages there are serious challenges for ensuring education for all by 2030. India has already missed EFA goals by 2015. Now after 2015 we have the similar challenges and need to focus on certain areas which are detrimental in realizing the rights based education for all by 2030;

1. Efforts should be made to establish or strengthen a national coordination mechanism for SDG 4—linking to the overall SDG coordination mechanism—with a high-level national body supported by technical committees; broaden its membership to include diverse sectors and civil society; and identify an appropriate SDG 4 coordination focal point.
2. Map existing policies and programmes that contribute to SDG 4 targets in preparation for national consultations.

3. Organize national and sub-national consultations to analyse the Education 2030 targets and Framework for Action in light of existing plans, policies and programmes to identify gaps and opportunities and to plan actions to implement and monitor SDG 4.
4. Build or strengthen inter-governmental cooperation to foster synergies and mutual learning for SDG 4.

Immediate actions by civil society organizations

1. Review and redefine the composition and terms of reference of the national mechanisms and develop a roadmap and a strategic plan in consultation with relevant stakeholders in order to provide effective support to national efforts toward SDG 4 (TWG-EFA).
2. Prepare advocacy/communication materials that provide key messages on SDG 4 in consultation with national government, (-EFA).
3. Map available data and data sources for SDG 4 indicators, including administrative data, household surveys, learning assessments and data collected by civil society, as well as capacity needs in data management, reporting and use .
4. Advocate with government for increasing spending on education to the tune of 6% of GDP/ 20% of budget spending.
5. Discourage private schooling in terms of elementary education, teachers education and state comes as sole stakeholder for SDG 4.
6. Advocate for identify and enrol the children in difficult circumstances, out of schools, girls and minority children and arrange schools for them.
7. Review the Education for ALL progress and gaps and push the new goals collectively.
8. Since the state governments don't show the political will judicial interventions should be launched.
9. The Incheon declaration and SDG 4 should be translated in local languages and massive awareness campaign should be organised.

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11. World Education Forum 2015 **ED/WEF2015/WD/2** 23 April 2015 Framework for Action Education 2030: Towards inclusive and equitable quality education and lifelong learning for all

Accessing Medicines for Reproductive Health

S. Srinivasan

Issues of affordability and access of medicines for reproductive health are closely tied to the perception of reproductive rights of women as inalienable and fundamental to human existence. Women matter most in patriarchal societies, like in much of India, during childbirth and that too for delivery of a male child. The number of girl children born per 1000 male children has been decreasing because of general discrimination towards girl children – this despite sex ratio at birth increasing since 2001. More girls than boys die under age 5.¹

In this chapter we focus on medicines for exercise of reproductive rights. Having these medicines in public health facilities in India along with other infrastructure like equipment and clean facilities, and functioning systems and trained personnel, are a necessary but not a sufficient precondition for the full exercise of reproductive rights.

Specifically, what are the medicines for Reproductive Health (RH)?

With respect to the situation in India, of urgency and priority are rational diagnosis, treatment and medicines, when needed, in the following areas of reproductive health:

- Maternal, perinatal and neonatal health which includes pregnancy, still births, childbirth, postpartum and newborn care²

1. T.K. Sundari Ravindran. Sex Selective Abortion and India's Declining Female Sex Ratio. At <http://www.commonhealth.in/factsheet-Sex-selective-abortion-and-declining-female-sex-ratio.pdf>. Accessed Sep 25, 2016. Child sex ratio has gone down in 2011 census to 919 girls per 1000 boys from 927 per 1000 in 2001 census. Source: <http://www.census2011.co.in/sexratio.php>

2. To quote the 2011 Janani Shishu Suraksha Karyakram (JSSK) document, the rationale for importance of maternal and child health is this inter alia: "About 67,000 women in India die every year due to pregnancy related

- Oral and hormonal contraceptives and devices like IUD, and condoms, female and male.
- Infertility counseling and treatment
- Abortion services
- Sexual health
- Violence against women
- Medicines for Reproductive Tract Infections/Sexually Transmitted Diseases
- Cervical and breast cancer
- HIV Medicines (ART, MTCT and Opportunistic Infections)
- Gender and rights and linkages between sexual and reproductive health (medicines may not be necessary here)

A comprehensive list of medicines for RH, at the international level, is the Interagency List of Essential Medicines for Reproductive Health (2006).³

In Annexure 2 of the Janani Shishu Suraksha Karyakram (JSSK) document, reproduced as Appendix 1 to this chapter, a list of medicines relevant for women before, during and after child birth is given. A brief perusal shows that all these medicines are made in India and are available in the wholesale/retail market generally. Affordability varies depending on medicine and its brands. Patenting is also not an issue except for a dozen medicines, mostly to do with cancers and HIV and some recent biosimilars (for example: trastuzumab (brand ‘Herceptin’) for breast cancer), sofosbuvir (for Hepatitis C). These are not mentioned in the essential drug list for maternal health (Appendix 1) but we nevertheless discuss these further below for their importance to the life cycle of a woman.

As regards affordability, we need to ask how many of these are under price control. To be under price control, the particular item needs to be in the National List of Essential

complications. Similarly, every year approximately 13 lakhs infants die within one year of birth. Out of the 9 lakh newborns who die within four weeks of birth (2/3rd of the infant deaths), about 7 lakh, i.e. 75 per cent, die within the first week (a majority of these in the first two days after birth). The first 28 days of infancy period are therefore very important and critical to save children. Both maternal and infant deaths could be reduced by ensuring timely access to quality services, both essential & emergency, in public health facilities without any burden of out of pocket expenses.”

See also: A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India. Ministry of Health and Family Welfare, Government of India, January 2013.

3. Available at http://apps.who.int/iris/bitstream/10665/69255/1/WHO_PSM_PAR_2006.1_eng.pdf, accessed Aug 20, 2016.

Medicines (NLEM) 2015. We find that almost all items are in the NLEM though not in the same strengths or presentations. But what is the extent of overpricing even if under price control? Table 1 gives an idea.

Essential Drugs for Maternal Health

Indeed there are some handful of drugs that are required to prevent maternal mortality (see Appendix 1). They are not costly but in their absence along with absence of supporting staff and infrastructure, and because of not following basic emergency obstetric procedures, a great many unnecessary deaths at and around childbirth occur.

The following drugs are especially crucial to prevention of maternal deaths around childbirth:⁴

- Oxytocin injections, to be kept in refrigerator, during delivery and after delivery (oxytocin is mainly used to prevent and treat hemorrhage after delivery. During labour, while it has its uses, it is often misused for irrational augmentation with harmful effects both for mother and baby.)
- Magnesium Sulphate injections, intravenous or intramuscular: used mainly for prevention and treatment of eclampsia (fits) in a woman with pre-eclampsia/eclampsia.
- Misoprostol tablets: used for induction of labour, and after childbirth for prevention and/or treatment of postpartum haemorrhage (excessive bleeding). It is also used for medical abortion, and in treatment of missed abortion/miscarriage.
- Mifepristone: also used for medical abortion followed by misoprostol
- Nifedipine tablets sublingual/oral to treat severe high blood pressure during pregnancy and/or when pre-eclampsia is diagnosed.
- Methergine tablets, or IV/IM: to control excessive bleeding following childbirth and spontaneous or voluntary abortion, and also to help expel products that remain after a missed abortion (miscarriage). It is available as tablets or injection (IM or IV). (Note: Both oxytocin and methergine need temperature maintenance. Often cold chain is not maintained during transport and in the store.)

All these medicines along with injectable saline solutions are easily available in India, and not expensive (see Table 1), but unfortunately these are not available in time in public health facilities or is not administered in the requisite regimen, and as a result avoidable

4. For more details on how these drugs are used in maternal health, see B.Subha Sri, Lindsay Barnes and Suchitra Dalvie. *Essential Drugs in Maternal Health, FAQs*. Common Health, RUWSEC and SAHAJ, June 2012.

maternal deaths occur. A situation worsened by lack of appropriate emergency treatment (like saline infusion to compensate for loss of blood) during transportation for referral, if transportation is available on time that is.⁵

Even simple iron plus folic acid tablets that do not cost much are not available in the retail market. Low iron levels in pregnant women results in risky pregnancies and deaths. More than half of women (55 percent) in India are anaemic - with 39% of women having mild anaemia, 15 percent with moderate anaemia, and 2 percent with severe anaemia. “Pregnant women are slightly more likely to be anaemic (59 percent) than non-pregnant women (55 percent).”⁶

Subha Sri and Renu Khanna analysed 124 maternal deaths (in 2012–13) across 10 major states of India, and found that about 28 per cent of the deaths are due to haemorrhage and 18 per cent of the maternal deaths reviewed were caused by anaemia. Abortion-related deaths were another 4 percent.⁷

Table 1: Procurement Prices of Some Crucial Drugs Used in Pregnancy and Childbirth of Rajasthan/Tamil Nadu Governments in comparison with DPCO 2013 Prices

Medicine Name	DPCO Aug 2016	RMSC	TNMSC	Use/Remarks
Oxytocin inj 5 IU/ml, per 1 ml ampoule	NA	1.85	3.30	Induction/augmentation of labour, management of incomplete or inevitable abortion
Magnesium Sulphate inj 500 mg /vial (50% w/v), per 2ml ampoule	NA	3.00	1.20	Pre eclampsia/ eclampsia and related fits
Misoprostol per 200 mcg tab	8.08	1.44	1.40	Medical abortion, induction of labour, termination of pregnancy, prevention/ treatment of post partum haemorrhage
Mifepristone per 200 mg tab	298.49	28.22		Used in combination with misoprostol to bring about an abortion.
Nifedipine 10 mg tab SR, per 10 tabs	11.50	3.69	1.12	For treatment of High BP during pregnancy, and during preterm labour

5. See Annexure 1, Details and Analysis of 124 Maternal Deaths, in: B. Subha Sri and Renu Khanna.(2014). *Dead Women Talking. A civil society report on maternal deaths in India*. Common Health and Jan Swasthya Abhiyan. Also: SAHAYOG and NAMHHR (2016). *Chronicles of Deaths Foretold*. SAHAYOG, Lucknow.

6. NFHS-3 Figures, accessed Oct 4, 2016 at http://rchiips.org/nfhs/nutrition_report_for_website_18sep09.pdf

7. B. Subha Sri and Renu Khanna.(2014), op.cit.

Methergine 0.2 mg/ml per 1 ml ampoule	NA	2.41	2.55	For contraction of uterus to expel retained products of miscarriage/ missed abortion, to prevent and control excessive bleeding, and in delivering the placenta
Labetalol inj 5mg/ml per 4 ml ampoule	168.12	34.98	47.17	For treatment of in pre-eclampsia for pregnancy induced high BP
Labetalol Tabs 100 mg per 10 tabs	NA	15.67	64.50	Ditto
Iron Folic Acid Tabs per 100 tabs	NA	10.24	8.95	Tablets are of standard strengths. Extremely low priced. But difficult to get in retail shops in India..
Iron sucrose injection 20 mg/ml in 5 ml ampoules	249.35	14.75	15.45	Treating iron deficiency anemia in pregnant women

Notes: Prices in Indian Rupees. RMSC =Rajasthan Medical Services Corporation. TNMSC = Tamil Nadu Medical Services Corporation. Prices are exclusive of taxes. DPCO 2013 (Drug Price Control Order) prices are as of Aug 2016. Source of all prices from the respective official websites, accessed September 19, 2016. For a more extensive list of medicines used during pregnancy and childbirth, see Appendix 1.NA means price not mentioned/could not be arrived at by the Government as per DPCO 2016.

Blood Availability

Many deaths occur around pregnancy because of lack of availability of blood in emergency situations. India collected 10.9 million units of blood in 2015-16 every year whereas the requirement is 12 million units every year (as per WHO norm based on 1% of the population).⁸ About one percent of all pregnancies need safe blood. There is a two hour window for saving the woman between massive bleeding and death.

The Government's National Blood Policy does not permit unbanked direct blood transfusions (UDBT) as it does for the armed forces where such blood transfusions are allowed.⁹ Nor does it permit coercion in replacement donors: that is for every unit of blood taken from the bank, a hospital is expected to replace it with a unit from a donor, usually a relative. This practice, called replacement donation, is against India's National Blood

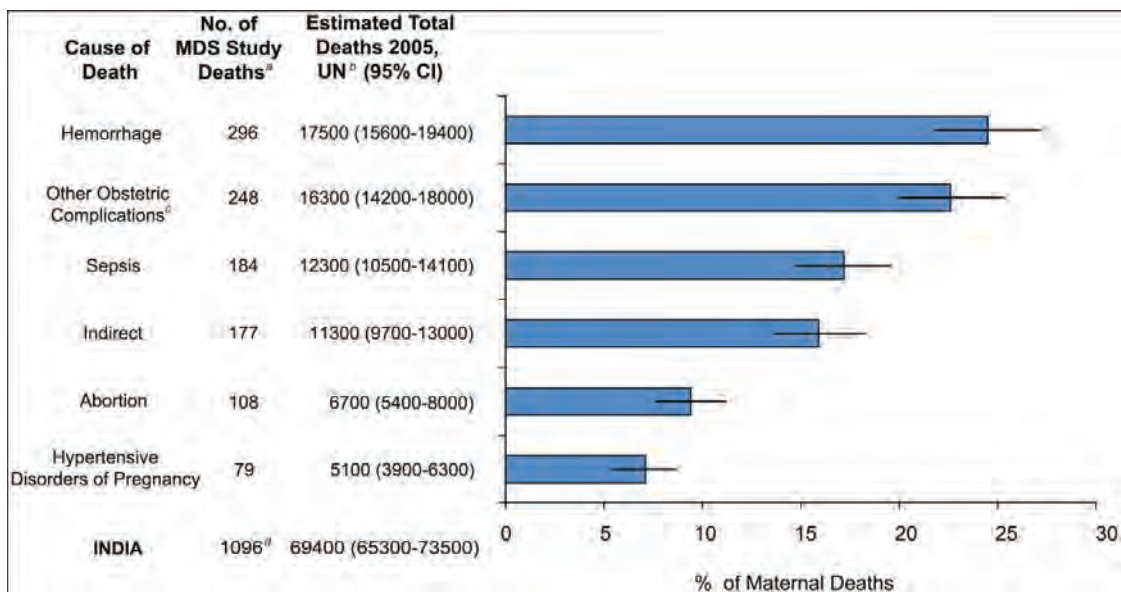
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9. Yogesh Jain, Raman Kataria. "Rural blood availability: regulations must meet ethics." Accessed August 23, 2016 at <http://www.issuesinmedicalethics.org/index.php/ijme/article/view/2409/4976>. Also: "Should hospitals give patients unbanked blood to save their lives?" by Menaka Rao, at Scroll.in, Aug 05, 2016. Accessed Aug 23, 2016, at <http://scroll.in/pulse/811681/short-of-blood-rural-hospital-cant-treat-patients-in-dire-need-of-it>

Policy, which does not allow coercion in soliciting replacement donors, and aims to phase replacement donations out.

The alternative therefore is to have functioning blood banks in every district and storage units in every First Referral Unit (FRU). Provision of blood should not be considered the responsibility of the immediate family. Voluntary blood donation should be encouraged on a war footing. Alternatives in the form of blood components, blood substitutes, and volume expanders need to be considered.

Cause of death distribution and estimation of annual number of maternal deaths by cause



Source of above graphic: Montgomery AL, Ram U, Kumar R, Jha P, for The Million Death Study Collaborators (2014) Maternal Mortality in India: Causes and Healthcare Service Use Based on a Nationally Representative Survey. *PLoS ONE* 9(1): e83331. doi:10.1371/journal.pone.0083331

Access to Medicines in Public Health Systems

At least two states – Tamil Nadu and Rajasthan – have a well thought out Free Medicines procurement, and supply chain and quality control systems and providing essential rational

10. See William Joe, et al. (2015). Maternal Mortality in India: A Review of Trends in Patterns. IEG Working Paper No. 315

drugs. Tamil Nadu launched the scheme way back in 1995. It provides all commonly prescribed medicines free of cost to all who attend the public health facilities from PHC to tertiary hospitals in the State.

In 2011, that is sixteen years later, Rajasthan launched similar schemes to provide free medicines and went one better by providing free diagnostics in 2013. Both these initiatives (see Table 2) have received critical acclaim by policy makers and experts all over the world. Delhi Government has a similar free medicine scheme. Their prices are well below even the Government's ceiling prices as per the Drug Price Control Order (DPCO) 2013. (See Table3)

Table 2: Free Medicine Schemes in Select States

States	Any declared Free Medicine Scheme (FMS) ?	Essential Medicines List?	No. of drugs in EDL	FMS Started since?	Medical Colleges included?	Any Free Diagnostics scheme?	Procurement method?	Any SPV (Special Purpose Vehicle)?
New Delhi	Yes	Yes	1390	2016	Yes	Yes	Partially Centralized	Centralised Procurement Agency
Rajasthan	Yes	Yes	602	2011	Yes	Yes	Centralized	Corporation
Tamil Nadu	Yes	Yes	305	1995	Yes	No	Centralized	Corporation
Kerala	Yes	Yes	588	2012	Yes	Yes	Centralized	Corporation

Source: Current status of gratis provisioning of essential and life saving medicines distribution in public hospitals to all patients in different states of India. Prayas, Rajasthan. Unpublished document, Sep 2016.

Table 3: Comparison between DPCO Ceiling Price and Rajasthan Govt Procurement Prices

Name of Drug, strength and Use/Date of NPPA notification	2. Simple Avg Ceiling price as per DPCO-2013 (April to Aug 2016)	3. RMSC procurement rates as on 2.8.16	4. DPCO-2013 ceiling price /RMSC rate in % (Col 2/Col 3)x 100
Imatinib Tab - 400 mg, 10 tabs 2.6.16	2133.20	172.90	1232
Temozolomide -250 mg, 1 tab 9.5.16	3552	100 (TNMSC 2015-16)	3552
Amlodipine Tab - 5 mg, 10 tabs 9.5.16	23.30	0.98	2377
Enalapril Maleate Tab - 5 mg, 10 tabs 23.6.16	29.70	1.58	1880
Atorvastatin Tab - 10 mg, 10 tabs 2.3.16	65.60	2.53	2592
Cetirizine Tab - 10 mg, 10 tabs 2.6.16	15.30	1.03	1484
Albendazole 400 mg, 10 tabs 23.6.16	71.50	7.86	909

¹TNMSC rate 2015-16. Note: Ceiling prices in Col 2 are as per latest NPPA notifications after April 2016. Source:http://rpsc.health.rajasthan.gov.in/content/dam/doiassets/Medical-and-Health-Portal/rajasthan-medical-corporation/pdf/RC_DRUGS/Alphabetical%20Live%20With%20PSU%20%20.8.16.pdf

Delhi Government has started a free medicine scheme in 2016, its performance will be watched even as it has too many drugs, many of them are not strictly rational. Kerala Government provides even branded medicines, at a discount, to those who can afford under its Karunya Pharmacy scheme.

On an average as a thumb rule 70% of the treatment expenses for an OPD patient are out of pocket and out of which 70 percent are for medicines. According to NSS 71st Round, "...more than 70% (72 per cent in the rural areas and 79 per cent in the urban areas) spells of ailment were treated in the private sector (consisting of private doctors, nursing homes, private hospitals, charitable institutions, etc.).¹¹ Further, "Expenditure on merely 6% hospitalised treatment in urban area was reimbursed partly or fully, whereas the similar figure for rural area was only a meagre 1%." About 80% of those seeking treatment do not/did not have health protection in the form of insurance etc and the treatment costs are mostly self financed.¹²

The upshot of this is that given the prices at which medicines are selling in India and given the sorry state of most public health facilities in most states, access to reproductive health as a right has a long way to go. But certainly one important factor for facilitating access for RH and health services is free medicines (including blood) apart from of course minimal health infrastructure and medical/paramedical personnel. Free medicine schemes are eminently doable as the average range of budgetary allocations for the states mentioned in Table 2 is about Rs 300 to 400 crores per state. The National Health Mission 'incentivises' up to 5 percent of the state health budget for free medicine scheme in the state. In general all the medicines, mentioned in the various essential medicine lists for Reproductive Health, are available under the free medicine schemes in these States.¹³

Patented Drugs

Several drugs of use in the life cycle of a woman are high priced and enjoy monopoly status. Many of them are also patented.¹⁴

11. Quoted in Para 3.2.5 along with graphic "Percentage distribution of spells of ailment treated during last 15 days by level of care separately for each gender" in *Key Indicators of Social Consumption in India*, NSS 71st Round, NSSO, June 2015, p.20.

12. See Statements 3.12 and 3.13, and related narration in NSS 71st Round, pp.28–29, op.cit.

13. See <http://www.rmhc.nic.in/pdf/Alphabetical%20Live%20With%20PSU.pdf> and http://www.tnmsc.com/tnmsc/new/user_pages/drugtender.php?drugcat=drug2016 and http://www.tnmsc.com/tnmsc/new/user_pages/drugtender.php?drugcat=sdg2015 Accessed Oct 4, 2016.

14. For an analysis of the patent-related conflicts that have bedevilled access to some molecules useful in prevention, diagnosis, and treatment of breast cancer, namely, Taxol, Tamoxifen, Herceptin, and the BRCA1 and BRCA2 genes,

These drugs (See Table 1) include those of use in rheumatoid arthritis, cancers and particularly breast cancer. Roche's patent on the breast cancer drug trastuzumab (brand Herceptin) was revoked by the Kolkata patents office because it did not appear in the patents court to defend its patent in a post-grant challenge despite reminders. Nevertheless there are problems of affordability even with the trastuzumab biosimilars being made by Biocon, the Bengaluru-based biotech company (in a tie up with Mylan), and those made by Reliance and Zydus Cadilla. In the meanwhile Roche has sought to restrain Biocon through court orders¹⁵ from claiming the Biocon product to be mentioned in its labels as a biosimilar to the Roche product.

During the last ten years many new medicines introduced in the Indian market have come with a patent monopoly and high, sometimes exorbitant, prices. Many of these medicines are for the treatment of life threatening diseases such as cancers. Table 4 provides a non-exhaustive list of medicines that have a monopoly in India and their prices.

Table 4: Selected examples of monopolies and prices of medicines

Medicine	Brand (Company)	Unit price (January 2016)	Common indication and dosing	Treatment cost
Dasatinib	Sprycel (BMS)	Rs. 3,287 per 50 mg tablet	Chronic phase Chronic Myeloid Leukemia (CML); 100 mg daily until disease progression or intolerance develops.	Rs. 6,574 per day. Annual cost is Rs. 23,99,510.
Cabazitaxel	Jevtana (Sanofi)	Rs. 3,30,000 per 60 mg single use injection vial	Advanced prostate cancer; 25 mg/m ² infusion every three weeks.	Approximate annual cost is Rs. 57,35,000.

see: Kane, Eileen. *Molecules and Conflict: Cancer, Patents, and Women's Health*. *American University Journal of Gender, Social Policy & the Law*, Vol. 15, No. 2, 2007. Available at SSRN: <http://ssrn.com/abstract=960772>. Accessed Sep 7, 2016.

15. <http://www.fiercepharma.com/pharma-asia/india-case-pitting-roche-vs-biocon-herceptin-biosim-trades-contempt-charges> and <http://health.economicstimes.indiatimes.com/news/pharma/roche-biocon-clash-accusing-contempt-of-court/53235577> . Accessed Sep 7, 2016.

Abatacept	Orencia (BMS)	Rs. 30,000 per 250 mg injection	Moderate to severe rheumatoid arthritis; 750 mg administered as infusion (assuming body weight >60 kg). Dose is repeated 2 and 4 weeks after initial dose, every 4 weeks thereafter.	Approximate annual cost is Rs. 12,60,000.
Temsirolimus	Torisel (Pfizer)	Rs. 70,971 per 25 mg injection	Advanced renal cell carcinoma; 25 mg infusion weekly until disease progression or unacceptable toxicity.	Approximate annual cost is Rs. 36,90,000.
Sunitinib	Sutent (Pfizer)	Rs. 8,715 per 50 mg tablet	Advanced renal cell carcinoma; 50 mg capsule daily for 4 weeks followed by 2 weeks off.	Approximate annual cost is Rs. 21,20,000.
Crizotinib	Crizalk (Pfizer)	Rs. 1,554 per 250 mg capsule	Locally advanced or metastatic non-small cell lung cancer; 250 mg twice a day.	Approximate annual cost is Rs. 11,34,000.

Table compiled by Malini Aisola with data source from PharmaTrac, Jan 2016

The way out of these high prices, and possibly the only way out, is to use the flexibilities available in the Patents Act, especially compulsory license (CL) and CL for government use provisions.

The provisions for Government use and acquisition of inventions and patents are laid out in Sections 92, 100 and 102 of the Act. However, the exercise of these powers is entirely upon the discretion of the Government. Ideally these decisions should not be exercised in an arbitrary and non-transparent manner. However, there is currently no institutional mechanism within the Government to exercise its discretion in a timely, accountable and transparent way.

In India, the high out-of-pocket expenditure on medicines is linked to catastrophic spending and impoverishment. In the face of the high prices of drugs and the undisputable evidence of their unaffordability in the Indian context [A recent study across six countries

revealed that India patented drugs were the least affordable in India, see “Priced out”, *The Economist*, June 11, 2016] there is no justification for why these powers have not been exercised even once over the last decade.

Cervical Cancer and HPV (Human Pappiloma Virus) Vaccine

After breast cancer, cervical cancer is “the second most common cancer in India in women accounting for 22.86% of all cancer cases in women and 12% of all cancer cases in both men and women ... One woman dies of cervical cancer every 8 minutes in India.”¹⁶

“Every year in India, 122,844 women are diagnosed with cervical cancer and 67,477 die from the disease. India has a population of 432.2 million women aged 15 years and older who are at risk of developing cancer.”¹⁷ The peak age of the incidence of cervical cancer in women is 55-59 years. Many in India report at a late stage, thus increasing the mortality.

Pap smear test (a procedure where a sample of cells from the cervix is examined under a microscope for cancerous and pre-cancerous lesions), visual inspection of the cervix, using acetic acid or iodine, liquid-based cytology, the HPV DNA testing of cells from the cervix, etc., are some methods used for early detection of cervical cancer before it turns invasive.

The HPV vaccine developed and promoted by Glaxo and Merck independently claims to prevent cervical cancer altogether. There are serious questions regarding the safety, and even efficacy of these vaccines.¹⁸ Available HPV vaccines (Gardasil and Cervarix of Merck and Glaxo) work only for 2, 4 or 9 of the 40 HPV strains. The Nordic Cochrane Center, a Danish research and information center, had questioned the European Medicines Agency’s (EMA) 2015 report on the HPV vaccines in a May 2016 letter,¹⁹ and the EMA’s position is that HPV vaccine benefits outweigh the risks.

There have been also controversies and deaths reported in India with concerned civil society organisations going to the Supreme Court on related issues of ethics and safety.²⁰

16. Source: <http://cancerindia.org.in/cp/index.php/know-about-cancer/statistics#cervical-cancer>. Accessed October 1, 2016.

17. CO Information Centre on HPV and cancer (Summary Report 2014-08-22). Human Papillomavirus and Related Diseases in India. 2014, quoted in Sreedevi A, Javed R, Dinesh A. Epidemiology of cervical cancer with special focus on India. *International Journal of Women’s Health*. 2015;7:405-414. doi:10.2147/IJWH.S50001.

18. Lucija Tomljenovic and Christopher A Shaw. Who Profits From Uncritical Acceptance of Biased Estimates of Vaccine Efficacy and Safety? *American Journal of Public Health*. July 2012. DOI: 0.2105/AJPH.2012.300837

19. Available at <http://nordic.cochrane.org/sites/nordic.cochrane.org/files/uploads/ResearchHighlights/Complaint-to-EMA-over-EMA.pdf>. Accessed Sep 6, 2016.

20. Sarojini, NB, et al. Undeniable Violations and Unidentifiable Violators. *Economic and Political Weekly*. June 11, 2011. Also Sarojini, N.B. et al. The HPV Vaccine: Science, Ethics and Regulation. *Economic and Political Weekly*, November 27, 2010.

However, the vaccine is likely to be introduced in India as part of the Government's UIP (Universal Immunisation Programme). HPV has already been introduced in Kerala, Tamil Nadu and Delhi. The Delhi State Government has introduced the vaccine for girls from 6th standard in private schools without any proper implementation plan or any preparedness. It does appear the pharma companies manufacturing these vaccines have shown an unusual interest in getting the vaccine introduced in India and have succeeded in their efforts. It is also a commentary on the modus operandi of deciding how and which vaccines are introduced in India.

Women and Medicines

There are differences between men and women in the way they react to medicines and various diseases. Some of these are because of biological differences and some because of gender, the social construction of these biological differences - that is attitudes, feelings, and behaviors that society and culture associates with a person's biological sex.

Differences in pharmacokinetics, pharmacodynamics, and physiology contribute to the phenomenon that women and men frequently respond differently to drugs. Hormonal influences, in addition, play an important role.²¹

Medicines (or drugs) specially affect women in special ways: drugs have effects on the reproductive system, especially during pregnancy and lactation. Drugs affect the foetus in many known and unknown ways. Drugs also pass through the breast milk and can affect the child. Sometimes some effects of drugs are latent and are visible only after some years either on the woman, or on her child or on the child's progeny. Women metabolise drugs differently than men. There is evidence to show that drug safety and efficacy data are not analysed by sex/biology only in a significant amount of studies. Women taking hormone containing contraceptives and drugs (as in hormonal replacement) need special study. There is also very little study and understanding of drugs in severely malnourished and underweight women especially in diseases like TB, malaria, dengue, chikungunya, HIV/AIDS, etc.

Some notorious drugs over the years involving women and children have been: thalidomide, diethyl stilbestrol or DES (see box below), high dose EP drugs, and injectable

21. See for instance: Y. Zopf, et al. Women encounter ADRs more often than do men. *Eur J Clin Pharmacol* (2008) 64: 999–1004. Decker MR, Seage GR 3rd, Hemenway D, et al. Intimate partner violence functions as both a risk marker and risk factor for women's HIV infection: findings from Indian husband-wife dyads. *J Acquir Immune Defic Syndr*, 2009; 51: 593–600.

contraceptives and implants like norplant, Net-En, depo provera and quinacrine. Net-En is likely to be introduced in the national family planning programme in India.²² Drugs of more recent concern have been anti-fertility vaccines and drugs used to induce ovulation. The most commonly prescribed ovulation drugs are clomiphene citrate (CC), aromatase inhibitors (such as letrozole), and gonadotropins (FSH, LH, human menopausal gonadotropin (hMG), chorionic gonadotropin (hCG)). Other medicines used in ovulation induction include bromocriptine, cabergoline, GnRH, GnRH analogs, and insulin-sensitizing agents.

The long term effects of these drugs, used in ART and IVF, are not clearly known.²³ (As an aside, at the time of going to press, the Government of India has come out with a bill that severely restricts surrogacy.²⁴)

22. Sushmi Dey. "Government to go ahead with birth control injections.". *Times of India*. Sep 27, 2015. At <http://timesofindia.indiatimes.com/india/Government-to-go-ahead-with-birth-control-injections/articleshow/49121432.cms>. Accessed Sep 19, 2016.

23. Brinton L. Long-term effects of ovulation-stimulating drugs on cancer risk. *Reprod Biomed Online*. 2007 Jul;15(1):38-44.

24. See for instance: Malavika Ravi. "A Critical Analysis of the Surrogacy Bill, 2016" at <http://www.feminisminindia.com/2016/08/31/critical-analysis-surrogacy-regulation-bill-2016/>. Accessed Sep 19, 2016.

And Anil Malhotra. "Draft surrogacy bill violates fundamental right of people to choose modes of parenthood." *Indian Express*, August 27, 2016. At <http://indianexpress.com/article/opinion/columns/surrogacy-bill-ban-commercial-2998128/>. Accessed Sep 19, 2016.

About Diethylstilbestrol (DES)

Diethylstilbestrol (DES) is a synthetic estrogen that was developed to supplement a woman's natural estrogen production. First prescribed by physicians in 1938 for women who experienced miscarriages or premature deliveries, DES was originally considered effective and safe for both the pregnant woman and the developing baby.

In the United States, an estimated 5-10 million persons were exposed to DES during 1938-1971, including women who were prescribed DES while pregnant and the female and male children born of these pregnancies. In 1971, the Food and Drug Administration (FDA) issued a Drug Bulletin advising physicians to stop prescribing DES to pregnant women because it was linked to a rare vaginal cancer in female offspring.

More than 30 years of research have confirmed that health risks are associated with DES exposure. However, not all exposed persons will experience the following DES-related health problems.

- Women prescribed DES while pregnant are at a modestly increased risk for breast cancer.
- Women exposed to DES before birth (in the womb), known as DES Daughters, are at an increased risk for clear cell adenocarcinoma (CCA) of the vagina and cervix, reproductive tract structural differences, pregnancy complications, and infertility. Although DES Daughters appear to be at highest risk for clear cell cancer in their teens and early 20s, cases have been reported in DES Daughters in their 30s and 40s (Hatch, 1998).
- Men exposed to DES before birth (in the womb), known as DES Sons, are at an increased risk for non-cancerous epididymal cysts.
- Researchers are still following the health of persons exposed to DES to determine whether other health problems occur as they grow older.

Source: <http://www.cdc.gov/des/consumers/about/effects.html>

Over the years there have been a whole slew of drugs whose teratogenic effects (that is drugs that can affect the development of the embryo or fetus) have come to be known: anti-cancer drugs, warfarin, anticonvulsants, inhalation anaesthetics, tobacco, alcohol, some psychotropic drugs and barbiturates, tetracyclines, chloremphenicol and some antimicrobial agents and aminoglycosides, antimalarials, antithyroid drugs, corticosteroids,

some sympathomimetic drugs, narcotics like morphine, heroin and methadone, and drugs used for premature labour and induced labour.

The leading medical research institutions in India have not explicitly considered gender and/or biology as a factor in drug reactions, clinical drugs and drug evaluation studies. There is a case certainly for a separate center for study on gender, biology and medicine at the national level in India and also a separate department on women and medicines in the CDSCO (Central Drugs Standard Control Organisation).

It is therefore necessary to demand from India's research institutions and the drug regulatory agency CDSCO that clinical trials of drugs and drug evaluations must be designed with respect to biological differences; indeed factors related to both gender and biology need to be incorporated in pharmacological studies and health studies in general, and associated policies.

Contraceptives

There are several methods of birth control or contraception. Of interest to women from a rights perspective is to have a safe method that does not depend on, or is not controlled by, a provider. None of the methods are guaranteed hundred percent to prevent pregnancy. (See Table below). Also, most if not all of them have complications and can cause severe disturbances on the female body from menstrual irregularities and bleeding to loss of bone density and proneness to cancer.

- Contraceptive methods can be broadly classified under:
- permanent sterilization methods (like tubectomy and vasectomy);
- long acting reversible contraceptives like IUD or Copper T, IUD with progestin, implantable rod with progestin inserted under the inside of the upper arm available in the market as brand NorPlant among others;
- injectable contraceptives like Depo-Provera (progestin injection shot) and Net En or norethisterone enantate;
- combined injectable contraceptives (CICs) that entails usually a monthly injection of a progestin and a synthetic estrogen taken to prevent pregnancy; and are usually effective up to 28-30 days.²⁵

25. CICs marketed include the following:

- Hydroxyprogesteronecaproate 250 mg and estradiol valerate 5 mg
- Dihydroxyprogesteroneacetophenide 150 mg and estradiol enanthate 10 mg

- short-acting hormonal methods like the oral contraceptive pill; the mini pill; the patch; the vaginal contraceptive ring;
- barrier methods like diaphragm with spermicide; sponge and/or cervical cap with spermicide; male/female condoms, etc.
- emergency contraception pills to be used within 72 hours or less after intercourse and available in India under the brand names I-Pill; Unwanted 72 etc.

Table 5: Comparison of birth control methods

Chance of pregnancy during first year of use		
Method	Typical use	Perfect use
Combination pill	9%	0.3%
Condom (female)	21%	5%
Condom (male)	18%	2%
Copper IUD	0.8%	0.6%
Depo-Provera	6%	0.2%
Diaphragm and spermicide	12%	6%
Fertility awareness	24%	0.4–5%
Hormonal IUD	0.2%	0.2%
Implant	0.05%	0.05%
Lactational amenorrhea method (6 months failure rate)	0-7.5%	<2%
No birth control	85%	85%
Patch	9%	0.3%
Progestin-only pill	13%	1.1%
Sterilization (female)	0.5%	0.5%
Sterilization (male)	0.15%	0.1%
Vaginal ring	9%	0.3%
Withdrawal	22%	4%

Source: <http://apps.who.int/iris/bitstream/10665/42511/1/9241545666.pdf> and Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC) (June 21, 2013). "U.S. Selected practice recommendations for contraceptive use, 2013: adapted from the World Health Organization Selected practice recommendations for contraceptive use, 2nd edition". MMWR Recommendations and Reports. 62 (5): 1–60.

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- Medroxyprogesterone acetate 25 mg and estradiol cypionate 5 mg
 - Norethisteroneenanthate 50 mg and estradiol valerate 5 mg
 - Megestrol acetate 25 mg and estradiol 3.5 mg

In India, sterilisation (male and female), male condoms, IUDs, emergency pills and oral contraceptive pills are more prevalent methods. And among these female sterilisation has had more takers – in fact more than 98 % of sterilisations are female sterilisations. Men wrongly think that they would lose their “virility” if they undergo vasectomy.²⁶ However, unsafe female sterilisation ‘camps’ resulting in many deaths has become a major concern. Although government family welfare programmes became ‘target free’ in 1996, in reality workers down the line are subjected to pressure to encourage women to adopt sterilisation. An incentive for sterilisation is given to the woman at Rs 1000 per sterilisation, and for the surgeons and the motivators, cars and DVD players, bikes, etc., are offered in some states.²⁷ For these and other reasons - the one time irreversible nature of the method is a big attraction - female sterilisation is the most “preferred” method of contraception, notwithstanding the so-called cafeteria approach, wherein a menu of contraceptive methods is on offer for the woman’s ‘choice’.²⁸ Availability, accessibility and affordability of safe contraceptive choices, and information about the same, is crucial to the exercise of reproductive rights of women, so that ‘choice’ does not remain merely on paper.

About fifty lakh (half a crore) women get sterilised in India every year and of the estimated women between ages of 20 to 64 (per census 2011), about 11 crore women in India are sterilised. About 55 % of the ever married women in this age group, about 27 crores, use contraceptives of one kind or the other and 75% of this 55 % is sterilised, which is about 11.4 crores.²⁹

Because of poor quality of the facilities available and non-compliance with standard operating procedures, a great many deaths occur. In a 2004 paper, Abhijit Das et al estimated that 19 of every 1,00,000 women who undergo tubectomies in India die – more than five times the rate reported by the government.³⁰ A figure which has probably not changed for the better since.

26. “As per the government data for the year 2015-16, of the total 41,41,502 sterilisations done in India, 40,61,462 were ‘tubectomies’, a term used for females. In the year 2014, out of a total 40,30,409 sterilisations, 39,52,043 were tubectomies and, in 2013-14, the corresponding numbers were 43,03,568 and 42,13,172.” Quoted in “Sterilisation in India only meant for women? Figures say only 2 per cent males participate in birth control”, <http://www.financialexpress.com/india-news/sterilisation-in-india-only-meant-for-women-figures-say-only-2-per-cent-males-participate-in-birth-control/390579/>. Accessed Sep 25, 2016.

27. Abhijit Das and Sana Contractor. India’s latest sterilisation camp massacre. Editorial. *BMJ* 2014;349:g7282

28. See also “Sterilisation deaths are the natural consequence of India’s obsession with population control,” Sep 16, 2016, *Scroll.in* at <http://scroll.in/pulse/816656/sterilisation-deaths-are-the-natural-consequence-of-indias-obsession-with-population-control>; and “Why hundreds of women have died in the government’s horrific sterilisation camps,” Sep 15, 2016, *Scroll.in* at <http://scroll.in/pulse/816587/why-hundreds-of-women-have-died-in-the-governments-horrific-sterilisation-camps>. Accessed Sep 20, 2016.

29. Abhijit Das, personal communication.

30. Abhijit Das, Ramakant Rai, Dinesh Singh. Medical Negligence and Rights Violation. *Economic and Political Weekly*, August 28, 2004.

The Supreme Court issued several directions for safe sterilisation in 2005 in *Ramakant Rai & Anr. v. Union of India & Ors* [WP (Civil) No. 209/2003.] These orders were supplemented by several guidelines by the Government of India and others.³¹ Neither these directions nor the Government guidelines have been implemented with sincerity in most states. Deaths of women continue. In a subsequent PIL [*Devika Biswas vs UOI*, WP (Civil) No, 95 of 2012], the Supreme Court, in September 2016, directed the Government of India “to persuade the State Governments to halt the system of holding sterilization camps as has been done by at least four States across the country,” and in any event, “the Union of India should adhere to its view that sterilization camps will be stopped within a period of three years.”

The indifference exhibited by the medical professionals and state government authorities to the deaths in female sterilisation camps constitutes the worst form of denial of right to life, health and reproductive rights.

Abortion Services

All matters related to reproduction and sexuality are a theatre of contestation between men and women, and between women, society and patriarchy. Among these issues are of course decisions related to conception, contraception and abortion, where power inequities between women and men play out in cruel forms, almost always to the detriment of women.

Abortion is termination of pregnancy. Women may want to terminate an unplanned or unwanted pregnancy for a variety of reasons. An abortion can be safe if done by trained personnel in a sterile environment. It can be unsafe and harmful and even fatal when done by persons lacking the necessary skills. Unsafe abortions contribute to 9% to 13% of the maternal mortality in India, that is around 12,000 deaths. In some districts of India, unsafe abortions are responsible for as much as 50% of the maternal mortality.³²

A miscarriage is a spontaneous abortion, affecting 10-15 % of all pregnancies, and is not to be conflated with induced abortion. There are two types of induced abortion: medical and surgical. The former is with the use of tablets – mifepristone and misoprostol – for pregnancies that can be carried up to 63 days (but allowed only up to 49 days as per India’s

31. See for instance, Renu Khanna and T.K. Sundari Ravindran (2015). *An Advocates’ Tool for Monitoring Rights-Based Provision of Contraceptive Information and Services in India*. SAHAJ and CommonHealth, March 2015.

32. Srivastava, P C, R K Rai, S Saxena, S K Roy Chaudhary and H K Singh (2013): “Unsafe Abortion: A Study in a Tertiary Care Hospital,” *Journal of Indian Academy of Forensic Medicine*, July- September, Vol 35, No 3, pp 0971–73. Quoted in “UPR Position Paper on Safe Abortion Access in India”, September 2016. Unpublished.

MTP Act), calculated from the date of the last menstrual period. In surgical abortion, instruments are used to evacuate the contents of the uterus. About 3 to 9 % of pregnancies are terminated due to induced abortion.

Abortion, or medical termination of pregnancy (MTP), is legal in Indian since 1971 when the MTP Act was passed. Section 3 of the Act says: “Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.” Despite this provision, the continued existence of Section 312 of the Indian Penal Code acts as a convenient tool for police and other authorities to book people offering even legal abortion.³³ This big window for criminalizing abortion, and in the absence of widespread knowledge of the MTP Act of 1971, is a severe deterrent for many to seek legal safe abortion.

As per the MTP Act of 1971, a woman can terminate her pregnancy up to 12 weeks based on a single opinion of a registered medical practitioner formed in good faith; and in case of pregnancies exceeding 12 weeks but less than 20 weeks, termination needs opinion of two doctors, that “(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury physical or mental health ; or (ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.”

During September 2016, a Bombay HC judgment [High Court On Its Own Motion vs The State Of Maharashtra on 19 September, 2016, *Suo Moto PIL*, No 1 of 2016) up turned the MTP Act clauses, especially, Section 3, by ruling that a woman should be allowed to opt out of an unwanted pregnancy irrespective of the reason (for example, notwithstanding the two conditionalities given in the previous para).³⁴

Safe abortion services are not freely available in India across classes and it is particularly difficult for unmarried women to access abortion services because of social pressures and taboos associated with it. Despite the MTP Act, only 1/6th of the 6 million abortions that take place in India are legal.³⁵

33. See section 312 of the Indian Penal Code: “312. Causing miscarriage.--Whoever voluntarily causes a woman with child to miscarry, shall if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine. Explanation.-A woman who causes herself to miscarry, is within the meaning of this section.”

34. For a newspaper report, see: http://economictimes.indiatimes.com/articleshow/54433759.cms?from=mdr&utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst. Accessed Sep 26, 2016.

35. Duggal R, Ramchandran V. The Abortion Assessment Project India: Key Findings and Recommendations. *Reprod Health Matters*. 2004 Nov; 12(24 Suppl):122-9.

Safe abortion services are a right of women, a reproductive right as much as right to safe delivery and safe contraception. One of the hindering factors in access to abortion is the cost of safe abortion services, with a variety of factors dictating the cost, not to mention other factors like marital status, government/private facility, etc.³⁶ Abortion services are supposed to be free in Government facilities but sadly it is not so because it is tied to adopting contraception (read sterilisation) immediately thereafter, and/or because adequate facilities – staff, medicines and equipments for MTP – are not available in all government facilities.

Hysterectomy as Contraceptive “Choice”

A related issue is the marketing of hysterectomy, a surgical operation that removes all or part of a woman’s uterus, as a contraceptive “option”. It may involve removal of the cervix, ovaries, fallopian tubes and other surrounding organs. The uterus or the “womb” is the place where the baby grows when a woman is pregnant, with the uterine lining acting as the source of menstrual blood. So when once the uterus is removed, the woman stops having periods and cannot get pregnant. Hysterectomies are medically justified, and when all else fails, in case of painful uterine fibroids (or lumps that grow on the uterus), uncontrolled excessive bleeding, or prolapse (when the uterus slides from its usual position into the vaginal canal) or due to, cervical cancer, cancer of the uterus, endometriosis (or growth of uterine lining outside the uterus), thickening of the uterus, etc. Hysterectomies are associated with higher risk of cardiovascular disease, stroke, urinary incontinence, and problems with sexual function, and are usually not the first option. Hysterectomy for a significant section of women has severe adverse effects including urinary incontinence, vaginal prolapse (part of the vagina coming out of the body), development of fistula (an abnormal connection between the vagina and bladder), chronic pelvic pain, etc and in some rare cases wound infections, blood clots, haemorrhage, and injury to surrounding organs, and in some cases higher frequency of heart problems and renal cancer.

According to Desai, et al., “the absence of primary treatment for gynaecological disorders, along with attitudes towards the uterus as being dispensable post-childbearing, has resulted in the normalization of hysterectomy.”³⁷

36. See: Shivani Patel. The Cost of Abortion in India. CommonHealth et al. At <http://www.commonhealth.in/factsheet-malaria-and%20sex-selective-abortion/1.%20factsheet%20The%20Cost%20of%20Abortion%20in%20India.pdf>. Accessed Sep 26, 2016.

37. Sapna Desai, Oona M.R. Campbell, Tara Sinha, Ajay Mahal and Simon Cousens. “Incidence and determinants of hysterectomy in a low-income setting in Gujarat, India.” *Health Policy and Planning*, 2016, 1–11
doi: 10.1093/heapol/czw099.

Among many reasons for the increase in unnecessary hysterectomies is the easy availability of reimbursement for the procedure (Rs 10,000 per surgery for the doctor) under the National Health Protection Scheme, formerly Rashtriya Swasthya Bima Yojana (RSBY) coupled with the selling of hysterectomy by providers as a cure all for all kinds of reproductive disorders. Among many poor women themselves, their immediate relatives persuade the women to believe that the uterus is a dispensable appendage of the body once birthing of children is over.

In Bihar it was being done, and continues to be, by doctors with an MBBS and not necessarily qualified in surgery. After 4 years of a scam of needless hysterectomy on vulnerable women being unearthed, the Bihar Human Rights Commission in April 2016 directed that the 702 women identified as having had unnecessary hysterectomies under the central scheme be compensated, with women under 40 years to be compensated Rs 2.5 lakh and those above 40 years Rs 1.5 lakh.³⁸

Similar incidents of gross violation of rights of women, mostly poor women, of being inflicted unwarranted hysterectomies, have been reported from other parts of the country, particularly the South. A study by the Karnataka Janaarogya Chaluvalli (KJC), an NGO working on health issues, showed high incidence of women undergoing hysterectomy in private hospitals in Kalburgi, specially those living in the Banjara tandas and in the neighbouring Omerga and Solapur cities of Maharashtra.³⁹

High levels of hysterectomy can also be a reflection of lack of availability of treatment for gynaecological problems like RTI, STI, menstrual problems, etc., especially in public health facilities.

Conclusion

We have tried to outline briefly some of the important areas where lack of access to medicines and related health services severely affects the exercise of reproductive rights by women,

38. See: Menaka Rao. "Bihar women who lost their wombs to needless surgeries suffer while doctors thrive" at <http://scroll.in/pulse/816202/bihar-women-who-lost-their-wombs-to-needless-surgeries-suffer-while-doctors-thrive>. Accessed Sep 20, 2016.

39. According to the Karnataka Janaarogya Chaluvalli (KJC) there are 38 hospitals in Gulbarga (renamed recently as Kalburgi) city alone conducting hysterectomies. See also: T.V. Sivanandan. "Taking Lambani women for a ride." *The Hindu*, April 15, 2015. Also at <http://www.thehindu.com/todays-paper/tp-national/taking-lambani-women-for-a-ride/article7532224.ece>. And an update at: "2,258 unwarranted hysterectomies in 30 months in Kalaburagi city: report.: At <http://www.thehindu.com/news/national/karnataka/2258-unwarranted-hysterectomies-in-30-months-in-kalaburagi-city-report/article8707328.ece>. See also: Roli Shrivastava. "Pushed into hysterectomies." *The Hindu*, June 11, 2016. Also at <http://www.thehindu.com/opinion/columns/column-article-by-rolisrivastava-pushed-into-hysterectomies/article8710537.ece>. Accessed Sep 20, 2016.

and the right to health and life. For lack of space, we have focused only on issues around conception, contraception and abortion and related maternal mortality. There are other health issues, and access to medicine issues, in the life cycle of a woman within, and beyond, the terrain of reproductive rights. They need a separate discussion. They are also a function of availability, accessibility and affordability of health services in general for all citizens of this country. But as a first step, if we can assure safe reproductive and child health services in India, health and dignity of women will get a boost beyond imagination. Indeed these are a function of how much dignity and respect society as a whole thinks women deserve, and how much society is free of gendered inequities. Gender equity and gender sensitivity in health services and in medical education is a good place to start with, if not in our schools for children below 18.

The JSSK (Janani Shishu Suraksha Karyakram) document of the Government of India mentions various entitlements⁴⁰:

Entitlement for Pregnant Women

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

Entitlements for Sick Newborn till 30 days after birth

- Free and zero expense treatment
- Free drugs & consumables

40. Annexure 1, Guidelines for Janani Shishu Suraksha Karyakram, 2011, Maternal Health Division Ministry of Health & Family Welfare Government of India, New Delhi.

- Free diagnostics
- Free provision of blood
- Free transport from home to health institution, between health institutions in case of referrals and drop back home
- Exemption from all kinds of user charges

These entitlements are a reality possibly in a couple of states in India. These need to be universal across India. Only then can we say reproductive rights and access to medicines, even then only a major part of it, are a reality.

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Mental Health and Reproductive Rights

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Introduction

India, the world's largest democracy inspite of making burgeoning endeavours and commitments towards women empowerment, continues to be plagued by significant human rights problems. Social sanctions to longstanding abusive practices, lack of education and shift of focus from the accountability of perpetrators are some of the major factors mediating and perpetuating human rights violations in our society. One of these travesties of justice is the violation of liberty and reproductive freedoms. The right to reproductive freedom is an integral part of universal fundamental right to life, liberty, equality, privacy and health. A complex interplay of socio-economic, cultural, and ethical values play a role in determining and controlling reproductive health in women. Numerous studies report that due to gender discrimination, violence, coercion and absence of decision-making, women in India are unable to exercise their reproductive rights [1]. Apart from these, child marriages, low level of education, early pregnancies, lack of access to contraception, inadequate medical care etc., have also been demonstrated to be important factors for failure of adequate expression of reproductive rights of woman [2].

The interface between mental health and reproductive health is a complex one. Reproductive physiology has been shown to exercise influence on the mood state, cognition and emotions of women and vice-versa [3]. Reproductive issues and hormonal factors are

also shown to influence the course and outcome of mental disorders. Also the major mental illnesses, such as schizophrenia and bipolar disorder have also been shown to have a bearing on reproductive and sexual health issues. Lastly, social issues influencing reproductive health e.g. child marriages, intimate partner violence, sexual coercion etc., often have significant impact on the mental health status of the victimized women.

Mentally ill persons have received inadequate care and concern of the community since time immemorial. Widespread stigma, and the inability of the mentally ill to protest against exploitation is a major cause of growing concern. The mental health issues associated with reproductive health have often been marginalised as a peripheral problem in general. Hence, for years the reproductive rights of the mentally ill persons have been relegated to the lowest priority zone for health planners and legislators. A recent focus on incorporation of principles of human rights and liberal jurisprudence in the respective legal system of nations has created the necessity and urgency of initiating appropriate steps for the care and treatment of mentally ill persons. But in spite of these efforts, the reproductive rights of the mentally ill do not receive the deserved cognizance and focus. Forced sterilizations and abortions of mentally ill women are some of the issues which demonstrate the vulnerability of the reproductive freedom of the mentally ill.

Historical developments

The World Health Organization (WHO) defines reproductive rights as follows “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.”

The integration of reproductive rights within the gamut of human rights began at the United Nation’s International Conference on Human Rights in 1968. The culmination of these initial efforts was the ‘Proclamation of Teheran’ which became the first international document to recognize to recognise reproductive rights as one of the indispensable human rights. The UN International Women’s Year Conference of 1975 supported the Proclamation of Teheran. This was followed by another landmark achievement, the “Cairo Programme of Action” which was adopted in 1994 at the International Conference on Population and Development (ICPD) in Cairo and proved to be a milestone in the history of reproductive rights. This Programme of Action emphasised the significant role of governments to uphold

responsibility to meet individuals' reproductive needs, rather than only setting demographic targets.

The Cairo Program also became the first international policy document to define Reproductive Health: "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes." With subsequent recommendations, issues related to HIV/AIDS, including need for prevention, treatment and education were incorporated into it. However the mental health issues surrounding the question of reproductive health, is yet to obtain its place in focus as well as policy related decisions.

In India, like most developing countries, there are clear variations in the acceptance and implementation of the Cairo programme's recommendations. No formal policy has been drawn on the basis of these recommendations. Furthermore women's reproductive mental health has been a scarcely researched area and unheard of till off late. Post-independence, various policies and programs have been formulated, directed towards the public health challenges like high maternal mortality, malnutrition, female feticide, contraception issues. However, the mental health aspect of reproductive health has yet to make its presence felt in the arena of policymaking.

Some of the policies and programs that are directly or indirectly geared towards women's reproductive health are: The Family Welfare Program, The National Population Policy, The National Health Policy, The National Rural Health Mission (NRHM), Janani Suraksha Yojana, Reproductive and Child Health Program RCH (I & II). But there is still a lack of clear guidelines pertaining to mental health issues related to reproductive health.

The Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol, which India signed and ratified in 2007, have created the legal space for engagement with the whole range of issues around disability, including sexuality and reproductive health that were hitherto invisible in public discourse. Furthermore, it is now binding on India to make existing legislation compliant with the CRPD. India has a growing women's movement and exponentially proliferating base of grass root NGOs committed to bringing rights and choice to women. However in spite of these endeavours, large proportions of women continue to face social and domestic pressures and constraints that limit their ability exercise reproductive freedom.

Major issues

Child marriage

About half of Indian women were married before the legal age of 18 years [4]. Studies show that early marriage and early childbirth leads to higher rates of adolescent fertility and pregnancy related complications. Child marriage besides being a blatant violation of child rights, also has detrimental psychological impact which in turn adversely affects the reproductive health of the girl child.

It also looms large as a major public health challenge since it perpetuates gender discrimination, illiteracy and malnutrition as well as high infant and maternal mortality rates, thus affecting reproductive and mental health in direct and indirect ways [5]. Child marriage practices put young girls at higher risk of psychological disorders as these girls will be denied the right to freely express their views and the right to be defended themselves against devastating traditional practices that in turn will increase risk of lifetime and recurrent psychiatric disorders. The overall lifetime and 12-month rates of psychiatric disorders have been found to be higher for women who married as children (before the age of 18 years), compared with women who married as adults [6]. This type of physical emotional and social anguish leads to greater psychological traumas such as immobility, loss of self-confidence and even among girls who were receiving education. Early marriage often impedes their education resulting in socio-occupational dysfunction, and inability to exert their independence in the society [7].

Policies by government or non-government agencies geared towards educating families and community, raising awareness amongst parents and empowering girls through education and employment can help stop early marriages [8]. Moreover education is not only effective in delaying marriages, pregnancies and childbearing but also school based knowledge of reproductive health issues can be effective in changing attitudes and practices that leads to risky sexual behaviour in marriage [9].

Intimate partner violence and sexual coercion

Intimate partner violence (IPV) is defined by WHO as “any behaviour within an intimate relationship that causes physical, psychological or sexual harm”. Male-to-female IPV has been established as a significant contributor to poor physical and mental health outcomes in women of all age groups. Intimate partner violence (IPV) is internationally recognized as

a fundamental violation of women's health and human rights and affects a large proportion of women and girls throughout our country.

Within India, IPV is widespread and has been linked to adverse physical, sexual and mental health consequences [10]. Current estimates from a national survey indicate that 35% of married women aged 15–49 had experienced physical violence from their current or former husband over the course of their married lives [11].

The mental health consequences of IPV have received research attention in the West. Depression has been shown to be a common consequence of IPV. A research group found that major depression was highly prevalent (68%) on a lifetime basis amongst female victims of IPV [12]. Another study found high levels of major depressive disorder (54%) in women with a history of IPV [13]. Overall, the likelihood of depression and suicidality has been reported to be 3 to 5 times greater for IPV victims compared to non-victims [14].

Several authors have also investigated the relationship between IPV and PTSD. A study found that 12 out of 14 women reporting IPV had symptoms of PTSD [15]. In addition, IPV severity was correlated with the intensity of PTSD symptoms, and psychological abuse was the strongest predictor of PTSD [16].

Although literature from developed nations has documented an association between IPV and mental health (both PTSD and Depression), there has been little research on the consequences of IPV from developing countries such as India [17]. As noted earlier, IPV has been documented as a significant problem in India but, even there, few studies have explored the antecedents or consequences of IPV.

IPV remains a problem of critical importance in India associated with poor reproductive outcomes, injury, psychological dysfunction, and suicide. The prevalence of IPV in India has been found to be 31.8–37.2% [18]. However, it was not uniform across the country. Psychological violence was the most common form (85.7%), followed by physical (71.4%) and sexual violence (57.1%) [19]. The major risk factors included low socio-economic status, unemployment and alcohol use in male partner, and marital dissatisfaction [20]. Protective factors included higher education level and employment status of women. IPV was significantly associated with increased physical injuries and adverse reproductive outcomes (termination of pregnancy, low birth weight and high infant mortality) [21]. Depression, somatic symptoms, PTSD, self-harm, and sleep disorders were also found to be significantly associated with IPV [22]. IPV also increased the risk for HIV and other STIs [23]. Not many definitive studies exploring effectiveness of interventions for the prevention of IPV were found.

The cross-sectional data from a recent study, in India showed an association between violence and a range of self-reported gynaecological complaints, low body mass index, depressive disorder, and attempted suicide. [In summary, women are subjected to an alarming amount of violence in childhood and adulthood, and the effects of this violence are often profound and long-term [24].

Another cross-sectional study involving interviews with over 2000 women living in Mumbai slums, IPV – physical (12%), emotional (8%) or sexual (2%) – was common during and after pregnancy [25]. A large study from Bhopal reported domestic violence in 13% of pregnancies, and a multisite study described figures of 26% for physical, 22% for sexual and 63% for psychological violence during pregnancy [26].

Compared with those who never experienced violence, the chances of reporting the most recent pregnancy as unintended was higher for those who experienced only physical violence, only sexual violence and both physical and sexual violence [27].

The most serious health effects of sexual coercion are not physical but psychological. While some acts may traumatize the survivor immediately, other acts may additively manifest many years later, making it more difficult over time to resist overt acts of aggression. Long-term clinical problems include hypervigilance, anxiety and phobias, somatic complaints, dissociative disorders, depression, substance abuse, suicide attempts, and risk of revictimization [28].

An exploratory study which looked into the prevalence of sexual coercion in female psychiatric patients in India found that sexual coercion was reported by up to 30% of the women. The most commonly reported experience was sexual intercourse involving threatened or actual physical force (reported by 14% of women), and the most commonly identified perpetrator was the woman's husband or intimate partner (15%), or a person in a position of authority in their community (10%) [29].

The consequences of gender-based violence and sexual coercion are devastating including life-long emotional distress, mental health issues including posttraumatic stress disorder and poor reproductive health. Common mental health problems experienced by abused women include depression, anxiety, posttraumatic stress, insomnia, and alcohol use disorders, as well as a range of somatic and psychological complaints. Battered women are much more likely to require psychiatric treatment and are much more likely to attempt suicide than non-battered women.

Male child preference

In India, as well as in several other countries of Asia, son preference has been pervasive for centuries. Son preference is deeply rooted in patriarchal cultural beliefs that give undue importance to having a son in a family. The kinship, inheritance, and value systems in traditional Indian family structures also inherently uphold son preference. The belief that sons are essential for social survival for a family by carrying on its lineage sustains the ideology of son preference. Women experience intense societal and familial pressure to produce a son and failure to do so, often carries the threat and consequences of violence or abandonment in their marriage [30]. Women may have many pregnancies until a boy is born—putting their own health at risk. The desire to have a son also contributes to the neglect or postnatal death of innumerable girls who are born but not desired. Studies clearly show that during early childhood, girls in India suffer health and nutritional discrimination [31]. Such societal pressures, take a toll on the physical as well as mental health of child bearing women, and pose a threat to their fundamental right to bear a child.

Fertility regulation

Contraceptives are crucial to women's ability to exercise their reproductive right to control their fertility and to make decisions about whether, when and how often to become pregnant. Yet, women's ability to exercise this right and to protect themselves against sexually transmitted disease is contingent on their status and position within the family and the broader society.

Contraceptive use interacts with mental health in two main ways. First, the methods themselves may have a direct effect on mood, through biological, biochemical or hormonal pathways. Second, decision-making about the initiation and continuation of contraceptive use may lead to conflict between partners; this, in association with other social determinants, can contribute to depression and anxiety in women. Such decision-making is likely to be influenced by beliefs about gender roles, autonomy and women's reproductive rights. To date, most research in the field has examined the direct effects of contraceptive methods on psychological distress or disorder. There is a need for increased research on sexuality, gender roles and gender relationships in different cultures, and in particular the effects of discrimination and violence against women.

Women who are mentally ill or who abuse alcohol or drugs may be unable to consent to sexual activity, are less likely to use contraception effectively, and are at high risk of sexual

exploitation [32]. They are as likely to be sexually active as women without mental illness. Hypomanic behaviour is associated with risky sexual behaviours, including intercourse with multiple partners and rates of unplanned pregnancy are high in women with severe mental illness. Compliance with methods that require regular self-administration, particularly oral contraceptives, is lower in women with psychiatric illness. Since some hormonal contraceptives may alter mood and contribute to depression, it is recommended that they are not prescribed to women who are currently depressed [33]. However, health professionals are less likely to discuss contraception with women who have serious psychiatric illness, and provision of contraception is problematic for groups who do not attend routine medical or reproductive health services[34].

Abortion

In India, under the Medical Termination of Pregnancy Act, 1972 abortion was legalised [35]. Despite that even today, a majority of women do not have access to safe abortion services. Legal abortion services are not easily accessible, and women continue to resort to unsafe practices and self-induced abortions, making their lives risky. Studies estimate that there are 2.2 illegal abortions for every legal abortion [36]. But nevertheless this is not an issue that has straightforward answers. Some feel that legalizing abortion continues to clearly be a tool for coercive population control. Women who do approach government facilities for abortions are somehow forced to 'accept' contraception/sterilization after the abortion is performed. It is also clear that unsafe abortion is a major cause of death and health complications for women especially of the child-bearing age [36]. Some data sources estimate that world-wide, one-third of all abortions are illegal. Almost 20 million unsafe abortions are performed annually, and estimates of the number of women who die from unsafe abortions all over the world range from 70,000-200,000 each year [37].

In India very few abortion literatures focus on mental health status of the abortion clients. A hospital based case control study found that women having an induced abortion had higher neuroticism than women in the spontaneous abortion group [38]. Feeling of guilt is very common between both groups of women. In general, psychological outcomes may be related to many factors such as parity, number of previous abortions, period of gestation, planning of pregnancy and abortion, marital, social and occupational adjustment, the effect of hospitalization, a woman's attitude and that of her family and the health personnel towards abortion, fear of the procedure, previous psychological status, factors such as age, literacy, marital and socio-economic status, type of family (nuclear or joint), number of living male

children, etc. are also reported to influence the psychological outcome of abortion [39]. Another hospital based study in Mumbai found that after 20 days of MTP, a majority of married and married women felt relieved, but a small percentage of women felt sorry, guilty or [40].

1. Section 3 of the MTP Act distinguishes the reasons of termination of pregnancy to be three fold:
2. As a health measure, when there is danger to the life or risk to physical or mental health of the women
3. On humanitarian grounds- such as when pregnancy arises from sex crime like rape or intercourse with a lunatic woman
4. Eugenic grounds- where there is a substantial risk that the child, if born, would suffer from deformities and diseases

Based on these statutes, there has been a tendency to consider mentally ill women, or women with intellectual disability unfit for procreation, and therefore candidates for termination of pregnancy, by virtue of their mental status. The MTP Act clearly lays down that a guardian can make decisions on behalf of a 'mentally ill person'. However one must respect the personal autonomy of a mentally retarded woman with regard to decisions about terminating a pregnancy. Obtaining consent, which is an essential condition for the termination of pregnancy is often not given due weightage in these women. Such dilutions of the requirement of consent often amount to an arbitrary and unreasonable restriction on the reproductive rights of the mentally ill. There are numerous social stereotypes and prejudices that operate to the detriment of mentally retarded persons. Often even medical experts and judges may unconsciously be susceptible to these prejudices. Persons with borderline, mild or moderate mental retardation are often capable of being good parents. Mental retardation is gauged on the basis of parameters such as intelligence quotient (IQ) and mental age (MA). It is quite possible that a person with a low IQ or MA can possess social and emotional capacities that enable him or her to be a good parent.

Forced Sterilization

A significant section of women in developing nations are forced or coerced by medical personnel to submit to permanent and irreversible sterilization procedures on a regular basis. Many women rely on voluntary sterilization to control their fertility, but often choice is an illusion. **Coerced sterilization** occurs when financial or other incentives,

misinformation, or intimidation tactics are used to compel an individual to undergo the procedure. Additionally, sterilization may be required as a condition of health services or employment. **Forced sterilization** occurs when a person is sterilized without her knowledge or is not given an opportunity to provide consent. Forced and coerced sterilizations are grave violations of human rights and medical ethics and can be described as acts undermining the inherent autonomy of a person and as degrading and dehumanising. Forcefully ending a woman's reproductive capacity may lead to extreme social isolation, family discord or abandonment, fear of medical professionals, and lifelong grief.

A survey conducted in India among women with disabilities revealed that six percent had been forcibly sterilized [41]. In many cases, people with disabilities who do not have guardians are also subject to rights abuses. Because of the pervasive stigma about disability, physicians may recommend sterilization or abortion and convince a disabled person's family members to approve the procedure, regardless of whether they are legally the person's guardian. Physicians may also perform the procedure at the request of family members who have not consulted the person with a disability.

Looking ahead

There is a scarcity of research exploring the mental health aspects of reproductive health in women. A collaborative approach amongst the disciplines of health sciences and social sciences are required to understand the biological as well as social aspects of reproductive mental health issues. Epidemiological studies are also needed to gauge the extent of the problem and the mediating factors associated with it.

A review of existing policies related to reproductive health, is essential to incorporate principles of mental health care. Sufficient interest is required to be garnered in the direction of preventive and treatment related programs, amongst policy makers.

Mental health issues in reproductive age group of women, is often mediated by social and culturally-rooted factors. Also a significant proportion of women are unaware of their reproductive rights, and the choices of regulating their fertility, family planning etc. to exercise their reproductive freedom. Educational activities and campaigns, in order to apprise women of the services that should be rightfully provided to them need to be framed and made accessible to all strata of women in the country. Awareness and educational campaigns to dispel myths and tackle age-old stereotypes related to son-preference, social sanctions to gender based violence and discrimination against women are required to deal with the social determinants of reproductive mental health.

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Reproductive Rights and the Right to Adequate Housing

As with many fundamental rights, the realization of both Reproductive Rights and the Right to Adequate Housing in Urban India are intimately intertwined. Deficiencies in one lead to violations of the other, and support for one makes realizing the other easier. Given the large number of Indian that live in urban areas, and the predicted growth of this population over the coming years, this connection is crucial to understand if efforts to improve Reproductive Rights are to succeed.

Housing Insecurity and Health Care

Homelessness and inadequate housing often lead to inadequate health care, including antenatal care deficiencies as well as substandard care during delivery and for infants. This is the result of the vicious cycle of inadequate housing leading to, and being the result of, general poverty; and poverty results in insufficient financial and social resources to access medical care.

There are several schemes and programs designed to provide health care services to the poor, but they are not fully implemented. For instance, there is a shortage of PUHCs in many urban centres. Even when there are health centers nearby, sometimes women face exclusion for social or economic reasons. This is true not only in slums and homeless

communities, but in relocation colonies as well. Baprola, a relocation colony here in New Delhi, was constructed without an ICDS/Anganwadi centre. More than a year after the initial residents were moved in, it remains unconstructed.

Further, forced relocations (e.g. slum evictions and demolitions) displace individuals and families, disconnecting pregnant and lactating women from whatever previous health care providers they did have access to, and disrupts the social networks that informally assist in reproductive health and child-care.

Additionally, the stigma of homelessness and poverty can result in denial of access to hospitals and other health care services that should be available to these individuals. But numerous organizations working on behalf of the poor report that their clients are discriminated against by health care providers, and told that they are not eligible for free services. And even if health care access is provided, for those that look homeless or extremely poor, it can come with such a rude and condescending attitude that they avoid it all together. This author was involved in attempts to get ICDS/Anganwadi services for women who were residing in a homeless women's shelter in Old Delhi. The nearby ICDS centres denied that their centre covered these women, and pushed back against several attempts to get services for these women.

Finally, homeless citizens and slum dwellers often face difficulties obtaining ration cards for bureaucratic reasons, and this can result in an inability to access various health services. They may have difficulty proving residency if their homes, along with their possessions and documents, have been destroyed. Government officials may demand bribes in order to process or "expedite" their application. Or the government may just declare that there are no more ration cards available at the time.

Housing Insecurity and Access to Education

Reproductive Rights and the Right to Education are also intertwined. Housing Insecurity can also lead to deficiencies in education, as slum dwelling and homeless children have difficulties gaining admission to public schools, may face discrimination in schools leading to higher drop-out rates, and may face evictions or relocations which disrupt schooling. Women and families should not be forced to have children in an environment where there are inadequate educational opportunities for their children. Likewise, lack of access to education can result in children that should otherwise be in school marrying too early. And underage marriage, coupled with lack of education, leads to women being less able to

control their reproductive options. Education rates also significantly affect access to ante natal health care (see, e.g., Suparna Ghosh-Jerath et al., Ante natal care (ANC) utilization, dietary practice and nutritional outcomes in pregnant and recently delivered women in urban slums of Delhi, India, *Reproductive Health* (2015) 12:20)

Slum and homeless communities often have limited access to schools. Even when there are government schools nearby, the children can be prevented from accessing them. For instance, in *HAQ vs. DDA & Ors*, WP (C) 5076 of 2011, HRLN argued on behalf of a community of farmers on the banks of the Yamuna River in Delhi. The children of these families had to walk long distances and cross dangerous multi-lane highways in order to get to the nearest government school. Some parents refused to let their children go, as earlier one had been killed by a car while crossing one of the roads. Further, the government had demolished a cow-shed that a local NGO had been using as an informal school for the young children in the community. This is on top of the social stigma that many children from slums and homeless communities face, which can lead to inadequate performance and further drop-outs.

Sadly, Relocation colonies are often no better. In *Sanchal Foundation vs. DDA & Ors*, WP(C) 790 of 2012, HRLN argued on behalf of residents from various communities in Delhi that had been relocated to Bawana. However, even after they were shifted there, the plot of land designated for a school remained empty. More recently, several other communities have been shifted to a relocation colony in Baprola. Many children were shifted in the middle of a school year with no provision for transportation to and from their old schools. There is no school yet within the Baprola Relocation Colony. The nearest schools are a 30 minute walk along a deserted and unsafe path, and they are already so overcrowded that they are refusing to admit the new students. HRLN is in the midst of filing petitions related to this and other deficiencies in relocation colonies here in Delhi.

Housing Insecurity and Environmental Risks

On top of the issues discussed above, urban Indians living on the street or in slums face added environmental risks which have significant negative implications for reproductive and infant health.

Homeless residents typically live in the open, where they are exposed to the elements (e.g. rain, cold, heat) and suffer the obvious health consequences. Additionally, for those that are living on sidewalks and next to roads, they face risks of increased air pollution

from traffic as well as being hit by cars and trucks. And without sanitation facilities, these residents are often living among rubbish (both their own as well as that of others thrown on the ground), and without access to toilet facilities.

Slum dwellers are often living in areas that do not have sanitation facilities or clean water. Without clean piped water, residents are often forced to buy water from private sources and/or carry jugs of water from tankers; and storing jugs of water in insanitary conditions can result in contamination of initially clean water. Even in the Baprola relocation colony, the residents were informed that the piped water was unfit for drinking. They were told they needed to fill jugs with clean water from a periodically refilled tank on the ground and carry them back up the stairs to their flats. Even this tanker delivery system was periodically suspended. The fact that the government allowed a private company to set up a clean water ATM in the colony speaks volumes as to the government's own commitment to providing clean water to the residents.

Additionally, without toilet facilities, residents are required to urinate and defecate in the open. Some slums may have public toilets, but even these are often not functional. For instance, in Baljeet Nagar, New Delhi, even after ordered to provide public toilets to an improperly demolished slum, the government did not provide water supplies to make them functional. Trash collection services are typically not available, and so the environmental conditions are extremely unhealthy. Additionally, without proper roads and other infrastructure, the risks of accidents in these areas are higher. As a result of all of these factors, the general health of the resident suffers – including malnutrition, injury, and infection diseases; and pregnant and lactating women, along with newborn children, are particularly vulnerable to these risks.

Housing Insecurity, Sexual Violence and Sex Trade

An often-undiscussed aspect of housing insecurity is the added risk of sexual violence that women face.

Poor women and girls, particularly those that are homeless and living on the street, face a significant increase in threats of sexual assault and rape. The lack of physical security from a proper house, along with the need to venture out in to the darkness to use the restroom, create an environment where they face daily threats to their dignity, their bodily integrity and even their lives. As a result of this threat environment, some women are forced in to sexual relationships with other men as a means of protection from sexual assaults from others.

Given the economic opportunities available to homeless women, it is unsurprising that some of them end up resorting to the sex trade as a means of survival. Sex workers in India face many obvious health threats – including STDs, unintended pregnancies and violence. And in a paternalistic attempt to protect women from these and other risks, some homeless shelters for pregnant and lactating women do not allow come and go at will, so some women choose to remain homeless to preserve their liberty.

On top of this, homeless women and slum dwellers face added barriers in pursuing police action and criminal justice in cases of sexual violence. These women may be viewed as untrustworthy or undeserving of help by the police because they are homeless and poor, and may be involved in sex work. To complicate matters even more, the police themselves maybe involved in the sex and drug trafficking that these women are caught up in, either through a protection racket or other forms of corruption.

Reproductive Health, Family Planning and Housing Insecurity

In addition to the Reproductive Health problems created by Housing Insecurity, the relationship goes the other direction as well. Early marriage, lack of access to family planning, and other reproductive health deficiencies can create housing insecurity.

Girls who marry at a young age are often prevented from finishing their schooling. This results in an education deficiency that leads to fewer and worse employment opportunities as well as other challenges which can exacerbate housing insecurity.

Additionally, women that are unable to access proper birth control and family planning services end up having more children than they would choose to, and children at times that may create particular financial hardships (e.g. while they are still in school, while they are caring for a sick family member or while they are away from home for employment reasons). All of these issues impact the financial resources of the women and their families, which can in turn result in housing insecurity.

Domestic Judicial Precedents

Numerous judicial opinions issued by the Indian Supreme Court and various High Courts address the Right to Housing in India. Several of the seminal cases include:

Shantistar Builders vs Narayan Khimalal Totame, AIR 1990 SC 630:

“9. Basic needs of man have traditionally been accepted to be the three - food, clothing and shelter. The right to life is guaranteed in any civilized society. That would take within its sweep the right to food, the right to clothing, the right to decent environment and a reasonable accommodation to live in. The difference between the need of an animal and a human being for shelter has to be kept in view. For the animal it is the bare protection of the body; for a human being it has to be a suitable accommodation which would allow him to grow in every aspect - physical, mental and intellectual. The Constitution aims at ensuring fuller development of every child.”

SHRI P. G. GUPTA Vs. STATE OF GUJRAT & ORS., 1995 (S2) SCC 182:

“11. As stated earlier, the right to residence and settlement is a fundamental right under Article 19(1)(e) and it is a facet of inseparable meaningful right to life under Article 21. Food, shelter and clothing are minimal human rights. The State has undertaken as its economic policy of planned development of the country and has undertaken massive housing schemes. As its part, allotment of houses was adopted, as is enjoined by Arts. 38, 39 and 46, Preamble and 19(1)(e), facilities and opportunities to the weaker sections of the society of the right to residence, make the life meaningful and liveable in equal status with dignity of person. It is, therefore, imperative of the State to provide permanent housing accommodation to the poor in the housing schemes undertaken by it or its instrumentalities within their economic means so that they could make the payment of the price in easy installments and have permanent settlement and residence assured under Article 19(1)(e) and 21 of the Constitution.”

Chameli Singh v State of UP, 1995 Supp (6) SCR 827:

“Right to social and economic justice conjointly commingles with right to shelter as an inseparable component for meaningful right to life. It was therefore, held that right to residence and settlement is a fundamental right under Article 19(1)(e) and it is a facet of inseparable meaningful right to life under Article 21. Food, shelter and clothing are minimal human rights.”

Ahmedabad Municipal Corporation v. Nawab Khan Gulab Khan, (1997) 11 SCC 121:

“It would, therefore, be the duty of the State to provide right to shelter to the poor and indigent weaker sections of the society in fulfillment of the constitutional objectives.

[...]

The right to life enshrined under Article 21 has been interpreted by this Court to include meaningful right to life and not merely animal existence as elaborated in several judgments of this Court including Hawkers' case, Olga Tellis case and the latest Chameli Singh's case and host of other decisions which need no reiteration. Suffice it to state that right to life would include right to live with human dignity. As held earlier, right to residence is one of the minimal human rights as fundamental right. Due to want of facilities and opportunities, the right to residence and settlement is an illusion to the rural and urban poor. Articles 38, 39 and 46 mandate the state, as its economic policy, to provide socio-economic justice to minimize inequalities in income and in opportunities and status. It positively charges the State to distribute its largess to the weaker sections of the society envisaged in Article 46 to make socio-economic justice a reality, meaningful and fruitful so as to make the life worth living with dignity of person and equality of status and to constantly improve excellence."

Sudama Singh & Ors. v Govt of NCT Delhi & Anr, (2011) Delhi High Court WP(C) 8904 of 2009

"44. [...] What very often is overlooked is that when a family living in a Jhuggi is forcibly evicted, each member loses a "bundle" of rights – the right to livelihood, to shelter, to health, to education, to access to civic amenities and public transport and above all, the right to live with dignity.

[...]

57. This Court would like to emphasise that the context of the MPD, jhuggi dwellers are not to be treated as "secondary" citizens. They are entitled to no less an access to basic survival needs as any other citizen. It is the State's constitutional and statutory obligation to ensure that if the jhuggi dweller is forcibly evicted and relocated, such jhuggi dweller is not worse off. The relocation has to be a meaningful exercise consistent with the rights to life, livelihood and dignity of such jhuggi dweller.

58. It is not uncommon to find a jhuggi dweller, with the bulldozer at the doorstep, desperately trying to save whatever precious little belongings and documents they have, which could perhaps testify to the fact that the jhuggi dweller resided at that place. These documents are literally a matter of life for a jhuggi dweller, since most relocation schemes require proof of residence before a "cut-off date". If these documents are either forcefully snatched away or destroyed (and very often they are) then the jhuggi dweller is unable to establish entitlement to resettlement.

Therefore, the exercise of conducting a survey has to be very carefully undertaken and with great deal of responsibility keeping in view the desperate need of the jhuggi dweller for an alternative accommodation.

[...]

60. The further concern is the lack of basic amenities at the relocated site. It is not uncommon that in the garb of evicting slums and „beautifying the city, the State agencies in fact end up creating more slums the only difference is that this time it is away from the gaze of the city dwellers. The relocated sites are invariably 30-40 kilometers away from a city centre. The situation in these relocated sites, for instance in Narela and Bhawana, are deplorable. The lack of basic amenities like drinking water, water for bathing and washing, sanitation, lack of access to affordable public transport, lack of schools and health care sectors, compound the problem for a jhuggi dweller at the relocated site. The places of their livelihood invariably continue to be located within the city. Naturally, therefore, their lives are worse off after forced eviction.

61. Each of the above factors will have to be borne in mind before any task for forceful eviction of a jhuggi cluster is undertaken by the State agencies. It cannot be expected that human beings in a jhuggi cluster will simply vanish if their homes are uprooted and their names effaced from government records. They are the citizens who help rest of the city to live a decent life they deserve protection and the respect of the rights to life and dignity which the Constitution guarantees them.

International Law

Article 25 of the Universal Declaration of Human Rights states that:

“everyone has the right to a standard of living adequate for the health and well-being of himself and his family including food, clothing, housing, medical care and necessary social services”

Article 11 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), (adopted by the UN General Assembly in 1966, entered in to force in 1976, and ratified by India in 1979) states that:

“1. The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions.”

Sample Housing Rights Cases Filed By HRLN

Here are a sample of some of the housing rights cases filed by HRLN in recent years.

Mukandi Lal Chauhan &Ors vs. MCD &Ors., WP(C) 9246 of 2009

This is one of several cases involving jhuggi dwellers that were clubbed together with the Sudama Singh case. These were residents in GadiaLoharBasti that were evicted by the MCD prior to the Commonwealth Games. The MCD claims the eviction occurred after they were told that the residents were not covered by any rehabilitation policy. See Sudama Singh above for quotes from the combined judgement.

HAQ vs. Govt of NCT Delhi &Ors, WP(C) 2033 of 2011

In this case, several hundred homes in Baljeet Nagar, New Delhi were demolished in a surprise eviction. Several bulldozers were accompanied by over 1,000 police who pushed the residents out of their homes and demolished almost 1,000 homes before we were able to get an emergency stay order along with directions for temporary relief. The final orders were for the government to perform a proper survey and rehabilitate all those found eligible. The government subsequently abandoned their attempts to evict these residents.

Maha Singh &Ors vs MCD &Ors, WP(C) 5372 of 2011

In this case, approximately 15 Dalit families living for decades in a cluster in Karol Bagh, New Delhi, received a threat of eviction. HRLN had filed a petition before the Delhi High Court, but the day before it was listed for its initial hearing, the government arrived with heavy machinery and demolished all the homes.

HAQ vs DDA &Ors, WP(C) 5076 of 2011

In this case, a community of farmers living in the flood plains of the Yamuna River in East Delhi had been subjected to periodic harassment and small-scale evictions. The government also demolished a building that a local NGO had been using as a school for the children of the farming families. HRLN was able to receive orders for the admission of the children in to local schools and transportation for them, as the walk was dangerous. But because of prior order directing the clearing of the river bed, the High Court did not provide for any rehabilitation of the residents.

Jhuggi Jhopri Ekta Manch vs MCD & Anr., WP(C) 6943 of 2011, WP(C) 3576 of 2012 and WP(C) 7457 of 2013

This is a series of petitions filed and refiled before the Delhi High Court related to residents living along a nala in East Kidwai Nagar, New Delhi. They had suffered an earlier partial demolition in 2009 in preparation for the Commonwealth Games, but they had not been evicted and the land had not been taken for any purpose. They were threatened with additional evictions in 2011, during which time HRLN filed a case to ensure that the residents were provided with proper rehabilitation. Initial directions were for a copy of the survey to be provided. The government did not follow the established rehabilitation procedures, and again threatened them with eviction in 2012, during which an additional petition was filed. Additional orders for surveys were given, though the government again failed to provide proper rehabilitation. Additional case was filed in 2013, and further orders for proper rehabilitation were provided. As of the current date, rehabilitation has not been provided.

NCDHR vs DDA & Anr., WP(C) 7388 of 2011 (Ravidas)

This was a case of residents in Ravidas, New Delhi living along a road being threatened with an eviction prior a proper survey or rehabilitation having been completed. HRLN filed a case and received a stay order with directions for the survey and rehabilitation to be performed.

Shakuntala & Ors vs DDA & Ors., WP(C) 7723 of 2011

Bipin Rai s. Union of India & Ors., WP(C) 7919 of 2011

This was a case of a surprise night-time demolition occurring in Aligaon, near Sarita Vihar in New Delhi. A regular Writ Petition and a subsequent PIL were filed. The case was disposed of after none of the respondents (including Union of India, Govt of NCT Delhi and UP Forest Department) would admit to having been involved in the demolition. However, because it was protected Forest Land, the Court would not direct In Situ rehabilitation.

Sanchal Foundation vs. DDA & Ors., WP(C) 790 of 2012

This was a case of several different communities in New Delhi having been surveyed and relocated to Bawana. However, during the survey and relocation, the DDA did not properly perform the survey and numerous residents that should have been found eligible

for relocation and provided rehabilitation were instead left out. Additionally, during the period that the petitioner NGO had been advocating for them via administrative avenues, a fire had broken out among some of the improperly denied residents jhuggis. The Court directed the DDA to re-evaluate the improperly denied residents applications for relocation, and directed temporary relief for those who had suffered from the fire.

Ajay Maken & Ors. vs. Union of India & Ors., WP(C) 11616 of 2015 (Shakur Basti)

This is a case that was originally filed by Ajay Maken as a PIL, and which HRLN got involved as counsel for several residents that were impleaded in to the case. It involved a jhuggi colony near a railroad station that was evicted without rehabilitation by the Railways Authority. The Court directed interim orders for emergency relief, as well as directions for the Delhi and Central Government bodies to come up with a unified and consistent protocol for evictions and rehabilitation. It is ongoing.

Asha Devi & Ors. vs Delhi Urban Shelter Improvement Board & Ors. WP(C) 617 of 2017

This is a case involving a community near NJ 24 in East Delhi that were at risk of eviction as a result of a road widening project. Of a larger group of jhuggis, approximately 150 were not surveyed, and in the days before the planned eviction, it was unclear whether the government planned to demolish their homes or not. HRLN filed a case and received stay orders protecting them from demolition. The government subsequently notified the residents that they would be surveyed. The case is ongoing.

Opportunities To Use Housing Rights To Further Reproductive Rights

In working to address and improve issues of reproductive health for the urban poor in India, adequate and secure housing is an important issue. General efforts to secure the Right to Housing can be made in order to improve reproductive rights, including efforts to secure in situ upgradation of slums, which would improve the environmental conditions for women and infants; and moratoriums and stay orders against evictions, which would reduce the risk of harm to women that these cause. There are several other specific strategies that can also be pursued.

One possible avenue is to pursue judicial orders requiring that adequate health facilities be provided in slums and other informal housing colonies, as well as all relocation colonies for evictees. The lack of access to health facilities in these housing colonies has a big impact

on women's access to ante natal care, facilities for delivery and care for newborns and small children.

Another possible avenue is to ensure that pregnant and lactating women are not subject to evictions, and when they are, that they are guaranteed relocation housing. Current relocation policies vary between States and Union Territories, but judicial orders could be sought declaring that, regardless of other eligibility criteria, pregnant and lactating women and their families should be guaranteed eligibility and relocation assistance.

Efforts could also be made to obtain court orders that all slum residents and homeless individuals, particularly women of child-bearing age, receive ration cards to ensure that they can avail themselves of the various health and nutrition benefits that they should be eligible.

CONCLUDING REMARKS

Gaps in SRHR services and implementation



“How does the Government expect us to receive quality care when the nearby Primary Health Centre is locked, and the nearest health centre is 50 kilometres away, there are no ambulance facilities and the connectivity is so bad that I and my infant might die on the way. So I prefer my village birth attendant, who gives me the service I require and I can afford it. `Gambhini, Manipur, 2017

India has seen significant progress in its health sector in recent years. The good news is **India reduced its maternal mortality rate** from 556 **deaths** per 100,000 live births to

174 between 1990 and 2015, according to the World Bank. Yet, establishing quality Sexual Reproductive Rights and Services has been a major challenge. The budget allocation for family planning is currently only 4% of the total Reproductive and Child Health (RCH) Flexi- Pool Budget. However the Union Health Ministry which proposed to increase its budget for the next financial year has failed to use about 40% of its allocation for family planning in the previous years. Around 60% of the funds allocated to family planning programme (which currently been repositioned to not only achieve population stabilisation, but also reduce maternal, infant and child mortality and morbidity.

India's lagging states like Uttar Pradesh (38%) followed by Bihar (48%), and Chhattisgarh (49%) are the high focus category states which have failed to strengthen and upgrade reproductive and child health services for women and children. Though, the government has proposed to increase budget allocation under National Health Mission, the flagship initiative of the Union Government, however effective allocation and utilisation is constrained by public financial management design, operational process, lack of health care providers and governance factors.

Though the Union Health Ministry has launched the Mission Parivar Vikas for over 146 high fertility districts that have a total fertility rate (TFR) and these districts currently contribute to 28% of the India's population. Maternal, infant and child mortality and morbidity through negligence and disrespectful care and abuse which leads to around 90% of the death in rural India is not even acknowledged. There is also no coordinated mechanism for collecting, analysing and using data about whether this large vulnerable population receive improved quality reproductive health services. Some of the key reproductive rights issues taken up in the High Court and Supreme Court which have been included in this edition are Quality of Care, Implementation of Schemes and Entitlements, Access to Safe Abortion Services, Child Marriage, Unmet Need for Contraception and Access to Adequate Nutrition.

HRLN has filed 1152 cases in the various High Court and Supreme Court on behalf of the key beneficiaries, who are **poor women** seeking health services in the public health centres, the community health centres and the district hospitals. **Women in conflict zones** who often find that it is impossible to hold the government responsible in a situation where there is armed conflict between the underground militants and the security forces, as a result of which all provision of services come to a grinding halt, **women in remote areas** particularly in the hills and forests where the roads are very poor and many pregnant women die in transit. They therefore prefer to have a trained traditional birth attendant at

home rather than to die on the road. **Tribals and dalits** who on account of their illiteracy, poverty and caste oppression are rarely inclined to stand up to the state unless organized. Health services in their areas are worst in the country. **Migrant women workers** who, on account of migration, often do not have valid documentation entitling them to free services in the state migrated too. **Women seeking abortions** in underground and unregistered institutions due to unawareness of their right to abortion services as well as the poor quality of services in government institutions. **Women seeking sterilization** are often lured into illegal sterilization operations done in unhygienic places, by unqualified and uncertified health personnel, often without an anaesthesia. **This book reflects a few cases from the spectrum of issues within reproductive health rights and services. The judgments from these cases will enhance** jurisprudence and will serve to support national network of lawyers who specialize in reproductive rights law.

Annexures

ABORTION

Nikhil Datar vs. Union of India (Civil Appeal - 7702/2014)

ITEM NO.106

COURT NO.6

SECTION IX

SUPREME COURT OF INDIA

RECORD OF PROCEEDINGS

CivilAppealNo(s). 7702/2014

NIKHIL DATAR

Appellant(s)

VERSUS

UNION OF INDIA & ANR.

Respondent(s)

(With officereport)

WITH

W.P.(C) No.308/2014

(With OfficeReport)

Date:15/12/2016

These appeals were called on for hearingtoday. CORAM:

HON'BLE MR. JUSTICE MADAN B.LOKUR

HON'BLE MR. JUSTICE ADARSH KUMAR GOEL

ForAppellant(s)	Mr. Colin Gonsalves, Sr.Adv. Mr. Kabir Ali, Adv. Mr. Zia Choudhary,Adv. Ms. Jyoti Mendiratta,Adv.
ForRespondent(s)	Mr. Aniruddha P.Mayee,Adv. Ms. V. Mohana, Sr. Adv. Ms. Kiran Bhardwaj, Adv. Ms. Movita, Adv. Mr. G.S. Makkar, Adv. Mr. D. S. Mahra,Adv. Mr. Joseph Aristotle, Adv. Ms. Loreign Quung, Adv. Ms. Tehmina Arora, Adv. Mr. Dheeraj Philip, Adv. Ms. Arpit Rai, Adv. Mr. Nishant Ramakantrao Katneshwarkar,Adv. UPON hearing the counsel the Court made the following

O R D E R

Learned counsel appearing for the Union of India should take instructions and file an affidavit on what the Union of India proposes to do in the matter.

List after the needful is done

(Meenakshi Kohli) (Jaswinder Kaur)

Court Master

Court Maste

Amita Kujur vs. State of Chhattisgarh & Ors. Writ Petition (Civil) No. 976/ 2016

HIGH COURT OF CHHATTISGARH, BILASPUR

Order Sheet

WPC No. 976 of 2016

Amita Kujur Versus State of Chhattisgarh

Ms. Rajni Soren, counsel for the petitioner. Mr. Ramakant Mishra, Dy. A.G. for the State. Heard.

The petitioner is a rape victim. She has lodged an FIR in P.S. Bagicha, District Jashpur (C.G.) on 21.03.2016 that she was subjected to rape between the period from 07.03.2015 to 13.03.2016. In view of facts disclosed, report was sent to P.S. Kansabel. It is stated in the petition that P.S. Kansabel has registered an offence against the accused alleging commission of offence under Section 376 IPC. The petitioner was subjected to Medical Legal Examination by Government Doctor in Government Hospital at Jashpur.

The petitioner has stated on affidavit in the petition that despite repeated representation and request made, she has not been taken to the hospital at Bilaspur for termination of pregnancy, despite willingness, as per the provision contained in Section 3 of the Medical Termination of Pregnancy Act, 1971 (for short “the Act of 1971”).

Learned counsel for the petitioner submits that as in the Government Hospital at Jashpur, pregnancy could not be terminated, for want of expert doctors, request was made to the Station House Officer to take the petitioner to Chhattisgarh Institute of Medical Sciences at Bilaspur where experts are available but she was advised to proceed of her own. The petitioner contacted the doctors in Gynecology Department of Chhattisgarh

Institute of Medical Sciences at Bilaspur on 12.04.2016 but the doctors expressed their inability on the ground that unless copy of FIR, MLC report and referral order of Jashpur Government Hospital presented, no further steps can be taken.

Learned counsel for the petitioner submits that according to the MLC report prepared by Government doctor at Jashpur, the period of 20 weeks, beyond which ordinarily the Act does not permit termination of pregnancy is expiring in couple of days. Therefore, a prayer has been made for emergent orders in the matter. It is submitted that if the petitioner is not subjected to medical examination today itself, serious complication may arise and the petition, itself, may be rendered fruitless.

The petitioner states that she is victim of rape and report has also been lodged in the Police Station. I have gone through the report lodged in the Police Station.

Under Section 3 of the Act of 1971, termination of pregnancy is permissible subject to fulfillment of condition and the opinion found by the medical practitioner. However, for the purposes of formation of opinion, medical examination of the petitioner would be necessary by the doctor. As even according to the petitioner, period of pregnancy exceeded 12 weeks, law requires her examination and recording of opinion by atleast two doctors.

If an order is not given to the petitioner today itself, delay in termination of pregnancy may cause grave injury. By virtue of explanation (I) anguish caused by pregnancy in a case of rape victim is presumed to constitute a grave injury to the mental health of the pregnantwoman.

In view of the above, a direction is issued to theDeen Chhattisgarh Institute of Medical Sciences Bilaspur to constitute immediately team of two doctors to perform medical examination of the petitioner form an opinion in terms of the provision contained in Section 3 of the Act of 1971 and takes suitable steps on the basis of such an opinion in the matter of termination of pregnancy.

Learned Deputy Advocate General shall directly inform the Dean Chhattisgarh Institute of Medical Sciences Bilaspur through the Collector of the District today itself.

On submission of copy of FIR before the Dean, the team of doctors shall proceed to medically examine the petitioner and such examination shall not be denied on the ground of non-production of referral letter orMLC.

The complete records of the case diary shall be brought by the Station House Officer, Kansabel before the CIMS authorityforthwith.

Learned State counsel shall inform Superintendent of Police, Jashpur that SHO Kansabel is required to immediately produce the case diary is concerning the case of the petitioner along with MLC report etc. before the CIMS authority at the earliest.

Certified copy to the petitioner today itself as also to the State counsel free of cost for necessary compliance.

List this case on 18.04.2016.

Sd/-

(Manindra Mohan Shrivastava)

J U D G E

Continued...

HIGH COURT OF CHHATTISGARH, BILASPUR

WPC No. 976 of 2016

Amita Kujur D/o Ignatius Kujur Aged About 23 Years R/o Badupara Mahadevdad

P.S. Bagicha District Jashpur Chhattisgarh

--- Petitioner

Versus

1. State Of Chhattisgarh Through Chief Secretary Mantralaya Naya Raipur Chhattisgarh.
2. Secretary Department Of Home Mantralaya Naya Raipur Chhattisgarh.
3. Secretary Department Of Health Mantralaya Naya Raipur Chhattisgarh
4. Collector Jashpur District Jashpur Chhattisgarh.
5. Superintendent Of Police Jashpur, District Jashpur (Chhattisgarh)
6. Thana In Charge P.S. Kansabel District Jashpur Chhattisgarh.
7. Ashok Pandey Erstwhile Thana In Charge P.S. Kansabel District Jashpur Chhattisgarh.
8. Chief Medical Health Officer District Hospital Jashpur District Jashpur Chhattisgarh.
9. Chhattisgarh Institute Of Medical Sciences Through Its Medical Superintendent CIMS Bilaspur District Bilaspur (Chhattisgarh)

--- Respondents

For Petitioner :

Ms. Rajni Soren, Advocate

For Respondents-State :

Shri Ramakant Mishra, Dy.A.G.

S.B.: Hon'ble Shri Justice Manindra Mohan Shrivastava

Continued...

Order On Board

20/04/2016

1. This petition has been filed by the petitioner, victim of a rape, for a direction to facilitate termination of her pregnancy, which according to her, is the result of commission of offence of rape on her.
2. On a petition filed before this Court by the petitioner, this Court directed medical examination of the petitioner to find out the gestational age. Pursuant to the direction issued by this Court on 13.4.2016, the petitioner was medically examined by a team of doctors. The case was directed to be listed on 18.4.2016. On 18.4.2016, learned counsel for the State made statement before this Court that the petitioner has been examined by a team of doctors. On this disclosure made, the report was directed to be filed on 18.4.2016 itself and the case was directed to be listed today. That is how the matter has come up for consideration before this Court.
3. Learned counsel for the petitioner argues that the petitioner is a tribal girl from Jashpur district who was abducted and taken to Alwar district of Rajasthan, where she was subjected to rape. After she was recovered, an FIR was lodged in Police Station - Bagicha on 21.3.2016, which was transferred to jurisdictional Police Station- Kansabel. A copy of the report has been placed on record as Annexure P-1. The petitioner having come to know that she had conceived as a result of rape, she represented to the Collector, Jashpur on 28.3.2016 to facilitate termination of her unwanted pregnancy. A representation was also made to the Superintendent of Police, Jashpur on 28.3.2016 itself. Those representations have been placed on record as Annexure P-2 collectively.

According to the pleadings, on 28.3.2016 itself, Additional Superintendent of Police & In-charge, Anti Human Trafficking Cell, assured immediate follow-up action and it is said that he telephonically instructed the police officers of Police Station- Kansabel to take necessary steps. It is the allegation of the petitioner that despite all steps taken by her informing the State and Police Authorities to facilitate termination of pregnancy and an approach made to Chief Medical and Health Officer, Jashpur, steps were not taken and she was advised to approach Chhattisgarh Institute of Medical Science (CIMS) Bilaspur. When she approached doctors at CIMS, she was informed that she needs to bring the copy of FIR, MLC report and a referral letter from District Hospital, Jashpur. As the State Authority and Police Authority did not facilitate termination of pregnancy, though strongly desired by the petitioner, to prevent herself from severe mental agony of carrying unwanted pregnancy, the petitioner has now knocked the doors of justice by filing this petition.

4. Relying upon the judgment of the Supreme Court in the case of Chandrakant Jayantilal Suthar & Anr. Vs. State of Gujarat t1, Suchita Srivastava & Anr. Vs. Chandigarh Administration 2 and order dated 19.2.2016 passed by the High Court of Gujarat in the case of Bhavikaben D/o. Rameshbhai Solanki Vs. State of Gujarat & Ors.3, prayer has been made to direct termination of pregnancy applying best interest theory and to prevent the petitioner from further mental agony which is a grave injury to the petitioner. Learned counsel for the petitioner has prayed

for issuance of immediate direction in that regard.

5. Learned counsel for the respondents-State submits that as per the direction of this Court, the petitioner was examined on 13.4.2016 by a team of doctors and report has been placed on record.
6. As per the medical examination report dated 13.4.2016 given by a team of two doctors, following opinion has been formed:

“Opinion: According to last menstrual period her gestational age is 20 weeks 4 days with P/A finding of pregnant uterus size 20-22 weeks and as per USG her mean gestational age is 20 weeks 4 days (copy enclosed). Hence according to MTP Act 1971 section 3 sub-section 2 b (copy enclosed), her pregnancy has exceeded the legal limit for MTP i.e. 20 weeks, therefore further direction is anticipated by the Hon'ble High Court, Chhattisgarh for further proceedings”

From the report, it is found that on 13.4.2016, the petitioner was found carrying pregnancy of more than 20 weeks.

7. At this stage, it is relevant to refer to the legal framework and the law of the land regulating the Medical Termination of Pregnancy Act, 1971 (hereinafter referred to as “the Act of 1971”). The circumstances under which pregnancy may be
 1. Order dated 28.7.2015 passed in SLP (Criminal) No.6013/2015
 2. (2009) 9 SCC 1
 3. Special Criminal Application (Direction) No.1155 of 2016

terminated by registered medical practitioners has been provided under Section 3 of the aforesaid Act, which reads as follows:

“3. When pregnancies may be terminated by registered medical practitioners.—

(1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner,—

(a) where the length of the pregnancy does not exceed twelve weeks, if such medical practitioner is, or

(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are,

of opinion, formed in good faith, that—

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Explanation I.—Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation II.—Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

(3) In determining whether the continuance of pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

(4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a [mentally ill person], shall be terminated except with the consent in writing of her guardian.

(b) Save as otherwise provided in clause (a), no pregnancy shall be terminated except with the consent of the pregnant woman."

The provision, as it reads, allows termination of pregnancy upon formation of opinion in good-faith with regard to circumstances specified in clause (i) & clause (ii) of sub-section (2) of Section 3 of the Act of 1971, quoted herein -above.

"Explanation -I provides in no uncertain terms that where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman."

8. The petitioner, a victim of rape, has clearly expressed her strong desire to avoid giving birth to child which is a result of rape on her. It has been stated in her pleadings in additional memorandum filed on 18.4.2016 that the petitioner has studied only up to Class-XII and did not go to college because of financial reason. Her mother passed away when she was young, her father is old and infirm. Presently she is financially dependent on her brothers who are married. Thereafter, what has been stated by the petitioner requires special mention and reproduction also as herein-below:

"The petitioner is under a lot of mental pressure and cannot bear stigma of being an unwed mother, she does not want to give birth to a child.

9. The situation which now stands as on today is that though the petitioner is not at all willing to carry pregnancy and seeks termination of her pregnancy so as to put an end to at least an agony of giving birth to an unwanted child, but the period of 20 weeks as provided in the Act has already elapsed. In fact, when the matter came up for consideration before this Court for the first time, the gestational period had crossed 20 weeks. As on today, the period of pregnancy is little more than 21 weeks.
10. The course of action which is required to be taken has to be guided by the principles of best interest theory laid down by the Supreme Court in the case of *Suchita Srivastava* (supra). In the aforesaid decision, the Supreme Court evolved the test and held that the Court is required to ascertain the course of action which would serve the best interests of the person in question. It has also emphasized that the Court must undertake a careful inquiry of the medical opinion on the feasibility of pregnancy as well as social circumstances faced by the victim. The Court's decision should be guided by the interests of the victim alone and not those of stakeholders such as guardians or society in general. The observation made by the Supreme Court in para-37 of the judgment need attention, which reads thus:

“37. As evident from its literal description, the “best interests” test requires the Court to ascertain the course of action which would serve the best interests of the person in question. In the present setting this means that the Court must undertake a careful inquiry of the medical opinion on the feasibility of the pregnancy as well as social circumstances faced by the victim. It is important to note that the Court’s decision should be guided by the interests of the victim alone and not those of the other stakeholders such as guardians or the society in general. It is evident that the woman in question will need care and assistance which will in turn entail some costs. However, that cannot be a ground for denying the exercise of reproductive rights.
11. A somewhat similar situation arose for consideration before the High Court of Gujarat in the case of *Bhavikaben* (supra). There the gestational age was of 24 weeks. That was also a case of rape victim. She tried to put an end to her life by consuming acid. She was ailing from medical problem also. Applying the best interest theory propounded by the Supreme Court in the case of *Suchita Srivastava* (supra) and the direction issued by the Supreme Court in another case of *Chandrakant Jayantilal Suthar* (supra), directions were issued for termination of medical pregnancy under supervision and care of doctors.
12. In the present case, the pregnancy has crossed 21 weeks of gestational age and unless there is judicial order as has been expressed in the opinion, it may not be possible for the doctors even to proceed with termination of pregnancy.
13. Taking into consideration the totality of the circumstances what has been stated by the victim, gestational age, judicial precedents, that as per Explanation -I appended to Section 3 of the Act of 1971 mental agony of a rape victim has to be treated as a case of grave injury, particularly taking into consideration that it is the interests of the victim alone which has to be kept in

view, this Court is inclined to direct the treating doctors to terminate the pregnancy. Taking into consideration that period of 21 weeks has elapsed, in order to ensure the safety of life of the petitioner, it would be proper to direct that the team of five doctors including those who have already conducted medical examination shall consider the feasibility of termination of pregnancy at this gestational age.

In view of the order of the Supreme Court in the case of Chandrakant (supra), it has to be left to the best opinion and judgment of medical experts in the matter. Once they find that at this stage, pregnancy can be terminated looking to the gestational age and overall condition of the petitioner, the same shall be carried out forthwith.

A copy of this order shall be supplied to learned counsel for the petitioner and Shri Ramakant Mishra, Dy.A.G., today itself, for immediate onward transmission to Dean, CIMS, Bilaspur for forthwith and immediate examination as per opinion, termination of pregnancy also .

14. This case is kept pending for the purposes of verifying the well-being of the petitioner after termination of pregnancy or for any other order which may be required to be passed in the matter including appropriate direction to be issued to the State Authority to avoid present situation.
15. The Hospital Authority shall take necessary tissues from fetus for DNA identification.
16. Respondent-State shall submit a report with regard to compliance of the Court direction on the next date of hearing.
17. List this matter on 25th April, 2016.

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(Manindra Mohan Shrivastava) Judge

HIGH COURT OF CHHATTISGARH, BILASPUR

Order Sheet

WPC No.976 of 2016

Amita Kujur Versus State of Chhattisgarh & Ors.

Mrs. X & Ors vs. Union of India & Ors Writ Petition (Civil) No. 81 of 2017

THE SUPREME COURT OF INDIA CIVIL ORIGINAL JURISDICTION

WRIT PETITION (CIVIL) NO. 81 OF 2017

Mrs. X AND ORS.

PETITIONER(S)

VERSUS

UNION OF INDIA AND ORS

RESPONDENT(S)

O R D E R

Application for non-disclosure of names and detail of petitioner No. 1 and 2 is allowed.

The Petitioner No. 1- Mrs. X is about 22 years' old. She has approached this Court under Article 32 of the Constitution of India seeking directions to the respondents to allow her to undergo medical termination of her pregnancy. According to her, fetus which is about 22 weeks old on the date of the petition has a condition known as bilateral renal agenesis and anhydramnios. She apprehends that the fetus has no chance of survival and the delivery may endanger her life.

In order to verify the condition of petitioner No. 1, this Court by order dated 03.02.2017 while issuing notice to the respondents directed examination of the petitioner by a medical Board consisting of following seven Doctors :

1. Dr. Avinash N. Supe, Director (Medical Education & Major Hospitals) & Dean (G&K) – Chairman
2. Dr. Shubhangi Parkar, Professor and HOD, Psychiatry, KEM Hospital
3. Dr. Amar Pazare, professor and HOD, Medicine, KEM Hospital
4. Dr. Indrani Hemantkumar Chincholi, Professor and HOD, Anaesthesia, KEM Hospital

5. Dr. Y.S. Nandanwar, Professor and HOD, Obstetrics, KEM Hospitals
6. Dr. Anahita Chauhan, Professor and Unit Head, Obstetrics & Gynecology, LTMMC and LTMGHospitals
7. Dr. Hemangini Thakkar, Addl. Professor, Radiology, KEM Hospital.

By its report dated 04.02.2017, the Medical Board as constituted by this Court has given its expert opinion upon reviewing the complete history as narrated by the petitioner No. 1 and her brother alongwith all the papers. The petitioner No. 1 was examined by all the Board Members with specific recourse to the specialty.

The learned Solicitor General who appears on behalf of Union of India had the report evaluated by Doctor Veena Dhawan from the Ministry of Health. The said Doctor does not disagree with the findings by the Medical Board and is also in agreement with the proposed action by the Medical Board. The salient features of the report are:

“.. Ultrasonography diagnosis is single live fetus with gestational age of 24 weeks 3 days with bilateral renal agenesis with double outlet right ventricle with ventricular septal defect with two vessel cord with anhydramnios....

Opinion of Pediatric Surgeon in charge of Birth Defect Clinic : There is risk of intrauterine fetal death/ still birth and there is no chance of long term post natal survival, and no curative treatment is available at present for bilateral renalagenesis.

There is thus a clear diagnosis of the condition of the single live fetus which is said to have bilateral renal agenesis which means the fetus has no kidneys and anhydramnios which means that there is an absence of amniotic fluid in the womb. Further, there is a clear observation that there is a risk of intrauterine fetal death, i.e. death within womb and there is no chance of a long term post natal survival. What is important is that there is no curative treatment available at present for bilateral renalagenesis.

The Medical Board has opined that the condition of the fetus is incompatible with extra-uterine life, i.e. outside the womb because prolonged absence of amniotic fluid results in pulmonary hypoplasia leading to severe respiratory insufficiency at birth. From the point of view of the petitioner the report has observed risk to the mother since continuation of pregnancy can endanger her physical and mental health.

We have already vide order dated 16.01.2017 upheld the right of a mother to preserve her life in view of foreseeable danger in case the pregnancy is allowed to run its full course. This Court in that case relied upon the case of *Suchita Srivastava and Anr. vs. Chandigarh Administration* [(2009) 9 SCC 1], where a bench of three Judges held “a woman’s right to make reproductive choices is also a dimension of ‘personal liberty’ as understood under Article 21 of the Constitution”.

In these circumstances we find that the right of bodily integrity calls for a permission to allow her to terminate her pregnancy. The report of the Medical Board clearly warrants the inference that

the continuance of the pregnancy involves the risk to the life of the petitioner and a possible grave injury to her physical or mental health as required by Section 3 (2)(i) of the Medical Termination of Pregnancy Act, 1971. It may be noted that Section 5 of the Act enables termination of pregnancy where an opinion is formed by not less than two medical practitioners in a case where opinion is for the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

Though the current pregnancy of the petitioner is about 24 weeks and endangers to the life and inevitable to the death of the fetus outside womb, we consider it appropriate to permit the petitioner to undergo termination of her pregnancy under the provisions of the Medical Termination of Pregnancy Act, 1971. We order accordingly.

The termination of pregnancy of petitioner no.1 will be performed by the Doctors of the hospital where she has undergone medical check-up. Further, termination of her pregnancy would be supervised by the above stated Medical Board who shall maintain complete record of the procedure which is to be performed on petitioner No.1 for termination of her pregnancy.

Shri Ranjit Kumar, learned solicitor General rightly points out that the affidavit in the present case is not sworn by petitioner No. 1 who seeks termination of her pregnancy and is sworn by a Doctor who is petitioner No.3. We might note that a relator action may not be permitted in a case of this kind. There would be various circumstances about which the Court must be assured of before the order is made. Conceivably, in a given case petitioner No. 1 may be under some misconception or under coercion. We do not find that to be the case here because Petitioner No. 1 has been examined by the Medical Board about her mental condition. In fact the Board has made a psychiatric evaluation of her and has stated that the patient is co-operative and coherent and has no psychiatric or emotional problems. Hence we do not propose to deny relief to petitioner No. 1. It is however, made clear that such action must be supported by affidavits of the petitioner No. 1 herself. Needless to state that KEM Hospital will take her consent before terminating her pregnancy.

With the aforesaid directions, the instant writ petition is allowed in terms of prayer (a) seeking direction to the respondents to allow petitioner no.1 to undergo medical termination of her pregnancy.

.....J

[S. A. BOBDE]

NEW DELHI; FEBRUARY
07, 2017.

.....J [L. NAGESWARA RAO]

Continued...

ITEMNO.4

COURTNO.9

SECTION X

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS
Writ Petition(s)(Civil)No(s). 81/2017

MRS. XANDORS

Petitioner(s)

VERSUS

UNION OF INDIA AND DORS

Respondent(s)

(With appln. for non-disclosure of names and details of the petitioner Nos. 1 & 2 and officer report)

Date : 07/02/2017 This petition was called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE S.A. BOBDE HON'BLE MR. JUSTICE L. NAGESWARA RAO

For Petitioner(s) Ms. Sneha Mukherjee, Adv.

Mr. Satya Mitra, Adv.

For Respondent(s) Mr. Ranjit Kumar, S.G.

Ms. Sadhana Sandhu, Adv. Mr. G.S. Makker, Adv.

Mr. Nishant R. Katneshwarkar, Adv.

UPON hearing the counsel the Court made the following

O R D E R

Application for non-disclosure of names and details of petitioner No. 1 and 2 is allowed.

With the directions contained in the signed order writ petition is allowed in terms of prayer (a) seeking direction to the respondents to allow petitioner No. 1 to undergo medical termination of her pregnancy.

[Charanjeet Kaur]

[Indu Pokhriyal]

A.R.-cum-P.S.

Court Master

[Signed reportable order is placed on the file]

**Sarmishtha Chakraborty & Anr. Vs. Union of India Secretary & Ors.
Writ Petition (Civil) N**

o. 431 of 2017

IN THE SUPREME COURT OF INDIA CIVIL

ORIGINAL JURISDICTION WRIT PETITION (C) NO.431 OF2017

SARMISHTHA CHAKRABORTTY&ANR.

Petitioner

VERSUS

UNION OF INDIA SECRETARY&ORS.

Respondent

O R D E R

The petitioners, the husband and wife, have moved this petition under Article 32 of the Constitution with manifold prayers. In the course of hearing, Mr. Colin Gonsalves, learned senior counsel appearing for the petitioners, has restricted his argument to prayer (g) which pertains to issue of direction for constituting a medical board to assess the pregnancy of the 1st petitioner and direct for termination of the pregnancy.

When the matter was listed on 21.6.2017, the Court took note of the prayer for appointment of a panel of doctors at a Government hospital in Kolkata to examine the state of health of the mother and accordingly directed the matter to be listed on 23.6.2017. When the matter was listed on 23.6.2017, this Court had passed the following order:-

In pursuance of the previous order of this Court “dated 21.06.2017,

ARORA learned standing counsel appearing on behalf of the State of West Bengal placed on the record his instructions indicating that a team of senior Doctors may be constituted to evaluate the mental and physical health of the first petitioner and the state of health of the foetus. At this stage, the pregnancy is in its 25th week.

The court has been apprised of the medical reports produced on record by the petitioners, including the opinion of Doctor Devi Shetty, which is annexed to the paperbook. We accordingly constitute a Medical Board consisting of the following Doctors to examine the first petitioner and her foetus at the Institute of Post Graduate Medical Education & Research (SSKM Hospital) situated at 244 A.J.C. Bose Road, Kolkata -700020:

NAME	HOSPITAL ATTACHED
Prof.(Dr.) Arati Biswas	National Medical College & Hospital
Prof (Dr.) Suchandra Mukherjee	I.P.G.M.E.R. (SSKM Hospital)
Prof(Dr.) Utpal Das	I.P.G.M.E.R. (SSKM Hospital)
Prof(Dr.) Subhas Chandra Biswas	I.P.G.M.E.R. (SSKM Hospital)
Prof(Dr.) Achyut Sarkar	I.P.G.M.E.R. (SSKM Hospital)
Prof(Dr.) Sujitesh Saha	I.P.G.M.E.R. (SSKM Hospital)
Prof(Dr.) Santanu Datta	I.P.G.M.E.R. (SSKM Hospital)

We request the Medical Board to examine the first petitioner and to submit its evaluation report of the first petitioner and the foetus to this court on 29.06.2017 in a sealed cover. A copy shall also be furnished to the Standing counsel for the State of West Bengal in sealed cover.

List on 29th June, 2017.”

In pursuance of the aforesaid order, a Medical Board was constituted and a report was submitted before this Court on 29.6.2017. Thereafter, the matter was directed to be listed today.

It is submitted by Mr. Colin Gonsalves, learned senior counsel appearing for the petitioners that the medical report clearly stipulates the condition of the 1st petitioner and if the report is appositely appreciated, the direction, as prayed for, deserves to be granted. We think it appropriate to reproduce the observations and opinion of various members of the Medical Board. The report of the Medical Board reads as under :-

“Observation of Dr. Utpalendu Das, Professor & H.O.D. of Radiology, IPGMER-SSKM Hospital, Kolkata- As per the available medical records including anomaly scan dated 25/05/2017 at gestational age of 20 weeks 5 days reveals single life intrauterine fetus with normal fetal anatomy and grown except cardiac anomaly with suggestion of Tetralogy of Fallot:

Fetal Echocardiography done on 6th June, 2017 reveals-

Tetralogy of Fallot Large perimembranous VSD with inlet extension (bidirectional flow)

Aorta from LV overriding the VSD Pulmonary atresia
Duct/MAPCA dependent pulmonary circulation Good Venticular Function

Opinion of Dr. Saroj Mondal, Asst. Professor of the Department of Cardiology, IPGMER-SSKM Hospital, Kolkata regarding continuation of pregnancy of Mrs. Sarmistha Chakraborty, who is carrying 20 weeks 5 days as on 25.05.2017 of pregnancy with normal fetal growth having fetal cardiac malformation detected by fetal echo cardiography on 6th June, 2017 in the form of Tetralogy of Fallot

Large perimembranous VSD with inlet extension (bidirectional flow)
Aorta from LV overriding the VSD Pulmonary atresia
Duct/MAPCA dependent pulmonary circulation Good Venticular Function

As the fetus has complex cardiac anomaly and if pregnancy continued mother will need delivery in a highly equipped centre with facility of neonatal cardiac intervention and surgical facility and will need multiple staged cardiac surgical operation and each occasion, it will have high morbidity and mortality risk.

This case, I already discussed with Dr. Achyut Sarkar, Associate Professor of the Department of Cardiology, IPGMER-SSKM Hospital, Kolkata who is appointed as Pediatric Cardiologist of this Medical Board.

Impression of Dr. Santanu Dutta, Associate Professor of the Department of C.T.V.S.

IPGMER-SS KM Hospital, Kolkata – As per the medical reports available, the fetal echocardiography shows Fetal complex congenital cyanotic heart disease.

Impression:

Pulmonary Atresia with Hypoplastic PAS, large VSD and collaterals arising from aorta.

It is evident from the report that the neonate needs complex cardiac corrective surgery stage by stage after birth. But there is high mortality at every step of this type of staged surgeries.

Opinion of Dr. Sujitesh Saha, Associate Professor of the Department of Paed. Surgery, IPGMER-SSKM Hospital, Kolkata

As per the medical reports and fetal echo cardiogram done on 6th June, 2017, the fetus is having tetralogy of Fallot, Pulmonary atresia and large VSD, Multiple Collaterals arising from aorta to support the pulmonary circulation. As per records, there is no other fetal congenital malformation detected.

On examination fetal growth parameters are normal. After birth multiple staged cardiac corrective surgery will be required which will be associated with high mortality and morbidity at every stage.

Opinion of Dr. Suchandra Mukherjee, Professor & HOD of Neonatology, IPGMER-SSKM Hospital, Kolkata

Pet the fetal echo-cardiography report dated 6th June, 2017, the fetus s having tetralogy of Fallot. Pulmonary atresia and large VSD, Multiple Collaterals arising from aorta to support the pulmonary circulation. No other fetal congenital malformation was demonstrated in the anomalies scan done at 20 weeks of gestation on 25th May 2017 and fetal growth parameter was found to be normal.

In view of the cardiac malformation, the baby, after birth will require intensive cardiac monitoring and staged management through the surgical procedures which will have high risk of morbidity and mortality depending upon the postnatal course.

Finally in pursuance of the Notice of the Director, IPGMER, Kolkata vide Memo N. Inst./5445 dated 23rd June, 2017, a medical board has been convened at 10.00 am on 27th June, 2017 in the Office Chamber of Dr. S.C. Biswas, Professor of the Department of Gynae & Obst, IPGMER-SSKM Hospital, in presence of all members of the constituted Medical Board by the Hon'ble Supreme Court, India. However, Associate Professor Dr. Achyut Sarkar, Department of Cardiology was absent. He deputed Dr. Saroj Mondal, instead of him to express the view of Pediatric Cardiologist, IPGMER-SSKM Hospital, Kolkata

The patient, 1st Petitioner of the case Mrs. Sarmisth Chakraborty, 33 years old, w/o Mr. Anirban Chakraborty was examined by the Board Members and all the members expressed their views. Two Gynaecologists, (1) Professor Subhash Chandra Biswas & (2) Professor Arati Biswas, on good faith examined the patient physically and observed the following findings:

Her L.M.P.-27.12.2016 E.D.D.-4.10.2017

& she is G2Po+1+0+0

Previous pregnancy- she had sudden bleeding P/V & pain abdomen at approximately seven and half months and delivered in Appolo Hospital, Kolkata, a still born baby vaginally (as per previous records) in 2015.

On examination-

She is conscious and co-operative with profound mental agony.

Her Vitals-stable

Per abdominal examination reveals

1. Fundal height of gravid uterus- 24 weeks+ (approx 26 weeks) (Corresponding to period of amenorrhoea)
2. Liquor-adequate (as per period of gestation)
3. Fetal parts-Palpable
4. F.H.S.+ & Regular

Patient, herself spontaneously expressed her wish not to continue this pregnancy in view of the detected fetal cardiac anomalies so far. On reviewing of the available records of the patient i.e. U.S.G., Fetal Echo-Cardiography including the prescription of the attending Obstetrician in Apollo Hospital, Kolkata, the other members of the Board (Radiologist, Cardiologist, Neonatologist, Pediatric Surgeon and Cardiac Surgeon) have opined that “the fetus has been detected to have cardiac malformation in the form of Tetralogy of Fallot, Large perimembranous VSD with inlet extension (bidirectional flow), Aorta from LV overriding the VSD, Pulmonary Atresia, Duct / MAPCA dependent pulmonary circulation and Good Ventricular function. The child, if born alive, need complex cardiac corrective surgery stage by stage after birth. But there is high mortality and morbidity at every step of this staged surgeries”. The cardiac anomaly has been confirmed by serial investigations.

In view of the above facts and opinion, we, the two Gynaecologists, in good faith like to opine that the patient is at the threat of severe mental injury, if the pregnancy is continued.

Therefore, if the patient wants termination of this pregnancy, she may be allowed with prior informed consent of inherent risk of her health for procedural interventions, because there is additional risk of termination of the pregnancy once it is beyond 20 weeks as the present case is. However, this is a special case and conclusion has been drawn on its individual merits.”

On a perusal of the aforesaid report, it is clear as crystal that the Medical Board is of the view that it is a case for termination of pregnancy, as a special case. As the last paragraph would show, the Board has mentioned that the patient is at the threat of severe mental injury, if the pregnancy is continued. It has also opined that the child, if born alive, needs complex cardiac corrective surgery stage by stage after birth. But there is high mortality and morbidity at every step of this staged surgeries.

Mr. Gonsalves, learned senior counsel has drawn our attention to two orders, one passed in *Meera Santosh Pal & Ors. vs. Union of India & Ors.* [WP (C) No. 17 of 2017 decided on 16.1.2017], wherein this Court, after considering the report of the Medical Board, has held thus :-

“Upon evaluation of petitioner no.1, the aforesaid Medical Board has concluded that her current pregnancy is of about 24 weeks. The condition of the fetus is not compatible with extra-uterine life. In other words, the fetus would not be able to survive outside the uterus.

Importantly, it is reported that the continuation of pregnancy can gravely endanger the physical and mental health of petitioner no.1 and the risk of her termination of pregnancy is within acceptable limits with institutional backup.”

Learned senior counsel has also drawn our attention to another order passed in *Mrs. X & Ors. vs. Union of India & Ors.* [WP (C) No.81 of 2017 decided on 7.3.2017] wherein this Court had allowed the termination of pregnancy. The Court had taken the Medical report into consideration which was to the following effect:

“There is thus a clear diagnosis of the condition of the single live fetus which is said to have bilateral renal agenesis which means the fetus has no kidneys and anhydramnios which means that there is an absence of amniotic fluid in the womb. Further, there is a clear observation that there is a risk of intrauterine fetal death, i.e. death within womb and there is no chance of a long term post natal survival. What is important is that there is no curative treatment available at present for bilateral renal agenesis.

The Medical Board has opined that the condition of the fetus is incompatible with extra-uterine life, i.e. outside the womb because prolonged absence of amniotic fluid results in pulmonary hypoplasia leading to severe respiratory insufficiency at birth. From the point of view of the petitioner the report has observed risk to the mother since continuation of pregnancy can endanger her physical and mental health.

Mr. A.K. Panda, learned senior counsel appearing for the Union of India has drawn our attention to two other orders, one passed in *Savita Sachin Patil & Ors. vs. Union of India and Ors.* [WP (C) No.121 of 2017 decided on 28.02.2017] and another in *Sheetal Shankar Salvi & Anr. vs. Union of India & Ors.* [W.P. No.174 of 2017 decided on 27.3.2017]. In the case of Savita Sachin Patil, the Court declined to grant permission by holding, thus:

“As regards the prognosis, the said medical report clearly does not and possibly cannot, observe that this particular fetus will have severe mental and physical challenges. It states that the *“baby is likely to have mental and physical challenges.”*

In the earlier part of the said medical report, there is no observation made by the aforesaid Medical Board that every baby with Down Syndrome has low intelligence, but it was observed that *“intelligence among people with Down Syndrome is variable and a large proportion may have an intelligence Quotient of less than 50 (severe mental retardation)”*.

In any case, it is not possible to discern the danger to the life of petitioner no.1 in case she is not allowed to terminate her pregnancy.

In the facts and circumstances of the case, it is not possible for us to grant permission to petitioner no.1 to terminate the life of the fetus.

In view of the above, as it presently advised, we decline the prayer (a) of the petitioners for directing the respondents to allow Petitioner No.1 to undergo medical termination of the pregnancy.”

In *Sheetal Shankar Salvi*, after perusing the report, the Court observed that there is no danger to mother's life and the likelihood that the baby may be born alive and survive for variable period of time, and, therefore, it would not be appropriate to allow the petitioner No.1 to undergo medical termination of her pregnancy.

The orders which have been referred to by Mr. Panda, in our considered opinion, rest on their own facts. Frankly speaking, cases of this nature have to rest on their own facts because it shall depend upon the nature of the report of the Medical Board and also the requisite consent as engrafted under the Medical Termination of Pregnancy Act, 1971.

In the instant case, as the report of the Medical Board, which we have produced, in entirety, clearly reveals that the mother shall suffer mental injury if the pregnancy is continued and there will be multiple problems if the child is born alive. That apart, the Medical Board has categorically arrived at a conclusion that in a special case of this nature, the pregnancy should be allowed to be terminated after 20 weeks.

In the case of *Suchita Srivastava & Anr. vs. Chandigarh Administration* [(2009) 9 SCC 1], the Court has expressed the view that the right of a woman to have reproductive choice is an inseparable part of her personal liberty, as envisaged under Article 21 of the Constitution. She has a sacrosanct right to have her bodily integrity. The case at hand, as we find, unless the pregnancy is allowed to be terminated, the life of the mother as well as that of the baby to be born will be in great danger. Such a situation cannot be countenanced in Court.

Regard being had to the aforesaid and keeping in view the report of the Medical Board, we are inclined to allow the prayer and direct medical termination of pregnancy of the 1st petitioner at the IPGMER-SSKM Hospital. The termination procedure to be carried out forthwith by the competent authorities of the IPGMER-SSKM Kolkata. For the sake of clarity, we may hasten to add that Mr. Gonsalves, upon obtaining instructions, has agreed for the said hospital. When we say, 'carried out forthwith' it depends when the 1st petitioner and her husband go to the hospital, it shall be conducted without any delay.

Accordingly, the Writ Petition is disposed of.

.....,J.
(Dipak Misra)

New Delhi; July 3, 2017

.....,J.
(A.M. Khanwilkar)

Continued...**ITEMNO. 56****COURT NO.2****SECTION X**

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS

Writ Petition(s)(Civil) No(s).431/2017

SARMISHTHA CHAKRABORTTY & ANR.

Petitioner(s)

VERSUS

UNION OF INDIA SECRETARY & ORS.

Respondent(s)

Date : 03-07-2017 This petition was called on for hearing today. CORAM: HON'BLE MR. JUSTICE DIPAKMISRA

HON'BLE MR. JUSTICE A.M. KHANWILKAR

For Petitioner(s)

Mr. Colin Gonsalves, Sr. Adv.

Ms. Sneha Mukherjee, Adv. Satya Mitra, AOR

For Respondent(s)

Mr. Chanchal Kumar Ganguli, AOR

Mr. Sankar Ch. Ghosh, Adv. Ms. Narmada, Adv.

Mr. A.K. Panda, Sr. Adv.

Mr. Swrapurna Chaturvedi, Adv. Mr. Vipin Kumar, Adv.

Mr. Gurmeet Singh Makker, AOR

UPON hearing the counsel the Court made the following

O R D E R

The writ petition is disposed of in terms of the signed order.

(Gulshan Kumar Arora)

(H.S. Parasher)

Court Master

Court Master

(Signed order is placed on the file)

**Sheetal Shankar Salvi & Anr. Vs. Union of India & Ors. Writ Petition
(Civil) No. 174 of 2017**

IN THE HIGH COURT OF DELHI AT NEW DELHI

W.P.(C)14064/2018

SHEETAL

Petitioner

Through: Ms.Sneha Mukherjee, Advocate versus

UNION OF INDIA & ORS

Respondents

Through: Mr. Dev. P. Bhardwaj, CGSC with Mr. Kamaldeep, Advocate for R-1 &
3 Mr. Anjum Javed, ASC with Mr.Devendra Kumar, Advocatefor R-2/
GNCTD

CORAM: HON'BLE MR. JUSTICE PRATEEK JALAN HON'BLE MR. JUSTICE
SANJEEV NARULA

O R D E R

% 04.01.2019

1. The petitioner in the present case is pregnant with a fetus of the gestational age of approximately 30 weeks. By this petition, she seeks medical termination of pregnancy, on the account that the fetus is suffering from a severe cardiac anomaly i.e. *tetralogy offalot*.
2. By an order dated 02.01.2019, we had requested the Medical Board constituted by the Ram Manohar Lohia Hospital to submit a further report on the consequences of the tentative diagnosis of *tetralogy offalot*. That report has been placed before ustoday.
3. The Court now has three Medical Reports forconsideration:

- (a) The first report dated 26.12.2018, submitted by Lady Hardinge Medical College, as recorded in Court's order dated 28.12.2018, stated as follows:

“The opinion of the board is as follows:-

- *As the pregnancy is in advanced stage i.e. 30 weeks period of gestation this foetus is viable.*
- *The cardiac anomaly detected on fetal echocardiography has standard Rx protocol including multistage surgery.*
- *However the prognosis will depend upon not only on postnatal confirmation of cardiac anomaly and presence or absence of other associated anomalies which may not be visible on antenatal USG.*
- *The baby needs to be delivered where tertiary care paediatric cardiac facility is available, which is currently not available in Lady Hardinge Medical College, New Delhi.”*

- (b) The opinion of the Medical Board constituted by RML Hospital, contained in the report dated 01.01.2019 was as follows:

1. *Continuation of pregnancy would not cause grave physical or mental injury to the mother.*
2. *Based on available evidence the child if born is not likely to have substantial risk of physical handicap. Possibility of substantial mental handicap cannot be predicted with the available evidence.*
3. *As the pregnancy is 30 weeks and baby has attained viability, now this will be a preterm delivery of a live baby and not medical termination of pregnancy. Yes, the delivery shall result in additional risk compared to delivery at term to the baby and mother.*
4. *At present, she is worried in view of perceived serious consequences to the fetus out of cardiac problem. She may suffer from psychological problems/psychiatric disorders on continuation of pregnancy. The risk for psychological problems/psychiatric disorders is also possible with preterm delivery.*
5. *Yes, the fetus has Tetralogy of Fallot (TOF) physiology (Tricuspid stenosis, hypoplastic RV and evolving functional pulmonary atresia). Final diagnosis needs to be confirmed in postnatal echo.”*

- (c) The opinion of the Medical Board submitted today states as follows:

“The patient is suffering from tricuspid stenosis, hypoplastic right ventricle and functional pulmonary atresia which is considered a form of tetralogy of fallot (TOF) physiology (decreased pulmonary blood flow) which is a broad entity encompassing several defects of which the index case is one of them. The diagnosis needs to be confirmed in post natal echocardiography so as to precisely determine the requirement of intervention and or surgery in each of these cases.

The baby will require delivery at a tertiary care facility with pediatric cardiology and neonatal cardiac surgery back up. The current treatment of this condition is in the form of palliative multi staged surgery. Depending upon factors which will be clear only after birth (adequacy of pulmonary blood flow, patency of the patent ductus arteriosus as well as the size of the branch pulmonary arteries). Either one or two surgeries may be required in the first year of life. Subsequent surgery will be done in the first decade of life.”

4. The picture that emerges from a consideration of these three reports is that the anomaly which has been detected does have a standard treatment protocol including surgery in various stages, both in the first year of life and thereafter in the first decade. Although the final diagnosis and required interventions will be determined only after post-natal tests, the Medical Board is of the opinion that the child is not likely to have substantial risk of physical handicap. The fetus is viable and that the procedure sought by the petitioner would involve pre-term delivery of a live baby and not a medical termination or pregnancy. The medical opinion also reveals that the continuation of the pregnancy would not cause grave physical or mental injury to the mother, and the risk of psychological problems / psychiatric disorders exists, both in the case of pre-term delivery, and also in case the pregnancy is carried to term. The report dated 01.01.2019 further categorically states that the delivery at this stage would result in an additional risk to the baby and mother, compared to the delivery at term.
5. In view of the medical opinion summarized above, we are unable to accede to the petitioner's request for permission to undergo medical termination of pregnancy at this stage. Unlike the present case, the orders of the Supreme Court cited by learned counsel for the petitioner, referred to in our order dated 02.01.2019, both concern cases where the opinion of the Medical Board was unequivocal. In *Sarmishtha Chakraborty vs. Union of India & Ors.* [order dated 03.07.2017 in W.P.(C) 431/2017], the Medical Board had opined that the multi-stage cardiac operations, which the child would be required to undergo, carried high risk of morbidity and mortality at each stage. The doctors were of the view that the patient was under threat of severe mental injury if the pregnancy is continued and that the patient's wish for termination of pregnancy may be allowed. Similarly in *Tapasya Umesh Pisal Vs. Union of India And Ors.* [order date 10.08.2017 in W.P.(C) 635/2017], the Court noted the medical opinion of high morbidity and mortality associated with the required surgeries, and the risk of continued physical incapacitation even after the surgeries. That was a case in which the pediatrician had reported that it appeared to be an isolated complex congenital heart disease and the cardiac surgeon had noted that there was a near certain chance of severe handicap or sudden death of the baby at birth. In *Sarmishtha Chakraborty* (supra), the Supreme Court has specifically cautioned that cases of this nature have to rest on their own facts, depending inter alia upon the nature of the report of the Medical Board. It is on this basis that the Court had distinguished the cases of *Savita Sachin Patil & Ors. Vs. Union of India and Ors.* [Order dated 28.02.2017 in W.P.(C) 121/2017] and *Sheetal Shankar Salvi & Anr. vs. Union of India & Ors.* [order dated 27.03.2017 in W.P.(C) 174/2017]. In those two cases, the Supreme Court had declined permission to undergo medical termination of pregnancy in the absence of a categorical opinion regarding the prospect of mental and physical handicap to the child, and the risk to the life of the mother.
6. For the reasons aforesaid, we are unable to grant the relief sought by the petitioner. Learned counsel for the petitioner does not press any of the other prayers in this petition.
7. The petition, therefore, stands disposed of.

PRATEEK JALAN, J.
(VACATION JUDGE)

Rajashri Nitesh Chadar Vs. Union of India & ors Writ Petition No. 13728 of 2017

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE
JURISDICTION
WRIT PETITION NO. 13728 OF 2017

RajashriNiteshChadar

...Petitioner

Versus

Union of India & ors.

...Respondents

...

Ms.Minal Kakalia a/w. Ms. Neha Phillip for thepetitioner.

Mr.Rui A. Rodrigues a/w. N. R. Prajapati, Mr. Upendra Lokegaonkar for respondent nos.1 & 3.

Mr.Sandeep Babar, AGP for respondent no.2.

Dr.Pravin A. Bangar, AMO, KEM Hospital Parel present. Ms.Pooja Yadav for MCGM.

...

CORAM : SHANTANU S. KEMKAR &
R. G. KETKAR, JJ.

DATE : 18th DECEMBER,2017.

P.C. :

1. Heard parties through their counsel. With consent heard and finally disposedof.
2. In this petition, on 13th December, 2017 while issuing notice to the respondents, the Medical Board of expert Doctors of Seth G. S. Medical College & KEM Hospital, Parel, Bombay was constituted by this Court to medically examine the petitioner as her pregnancy was stated to be of 22 weeks so as to form opinion whether it wouldbeappropriate to direct respondent

no.2 to allow the petitioner to carry out the medical termination of pregnancy in view of the various serious infirmities found in the certificate filed by the petitioner from Nanavati Super Specialty Hospital.

3. In pursuance of the order passed by this Court the Medical Board of G. S. Medical College & KEM Hospital, Parel, Bombay has submitted its report dated 15th December, 2017. On going through the report it appears that the Medical Board has examined the petitioner's physical condition and has given its opinion.
4. The relevant portion of the opinion of the Medical Board reads as under;
 - “7. Obstetric examination shows about 2224 weeks pregnancy, the petitioner herself is in fair health at present.
 8. Ultrasonographic Diagnosis Is Single Live Fetus with Gestational age of 23 weeks with Dandy Walker malformation.
 9. As per neurological review, with Dandy Walker malformation. The fetus after birth may have mental retardation, seizures and ataxia. The possible severity of these disabilities cannot be quantified at present.
 10. As per pediatric surgical review, there is no surgical cure for Dandy Walker malformation.
 11. Pre-anesthetic assessment the patient is fit for general/regional anesthesia.”
5. Based upon the aforesaid findings, the Medical Board has stated as under;
 - “1. The child if born, viable, has possible risk of mental retardation, ataxia and seizures which cannot be quantified at present.
 2. If the pregnancy is terminated now as per the patient's and her family's request:
 - (a) The most common complication of second trimester medical abortion is retained placenta, which is estimated to occur at a rate of 15% to 50%.
 - (b) Other complications of medical abortion include hemorrhage requiring transfusion (1%), infection (2.6%), and failed abortion.
 - (c) In advanced gestational age cases induction time is longer and risk of hemorrhage is greater.
 - (d) The mortality rate with abortions performed at eight weeks or earlier was 0.1 deaths per 100,000 legal terminations, and rises to 8.9 deaths per 100,000 abortions for those at 21 weeks or later. Mortality with abortions after 20 weeks is higher than that with natural livebirths.
 - (e) If induction fails, the patient may require hysterotomy for maternal indication; in that case, in future pregnancy there is small chance of rupture of scar (about 1%), the relative risk of morbidly adherent placenta is 3 to 5 (as per available statistics).

- (f) At present there is no evidence of any physical risk to maternal health owing to the reported fetal malformations.

In view of the above, the Medical Board is of the opinion that termination of pregnancy may have substantial physical risks for the patient. These risks are stated based on available scientific evidence.”

6. We have also noticed that as directed by this Court, in regard to the pros and cons of proposed termination of pregnancy, counseling to the petitioner and her family members was done by the said Medical Board and the petitioner has expressed her willingness to take the risk.
7. Having regard to the aforesaid, in our considered view it would be appropriate to allow the petitioner to terminate the pregnancy as the fetus after birth will be of various serious infirmities as reflected in the opinion as aforesaid, in the circumstances, we allow this petition and direct the petitioner to remain present in the said hospital on 19th December, 2017 so that the termination of pregnancy can be carried out within a day or two as may be deemed fit by the Medical Board.
8. We also make it clear that the Medical Board which has examined the petitioner as per our directions will not be held liable for submitting their report and they will not be held liable for any litigation arising therefrom. We also make it clear that the petitioner has been made aware about the risk involved in carrying out the medical termination of pregnancy and she has taken the prompt decision to undertake the risk by carrying out the medical termination of pregnancy.
9. We direct learned AGP to appraise the Dean of the said hospital. We also direct Ms. Yadav, counsel who generally appears for Municipal Corporation to inform the said Hospital so that the appropriate arrangement of termination of pregnancy can be done.
10. Parties to act on an authenticated copy of this order.
11. Needless to say that the petitioner will bear the necessary expenses as per the norms of the hospital.
12. With aforesaid directions, petition is disposed of.

(R.G.KETKAR,J.) (SHANTANU S. KEMKAR,J.)

Gausiya Gulam Pathan vs Union of India & Ors Writ Petition No.13228 Of 2017

IN THE HIGH COURT OF JUDICATURE AT BOMBAY APPELLATE CIVIL
JURISDICTION

WRIT PETITION NO.13228 OF 2017

Gausiya Gulam Pathan

Petitioner

vs

Union of India & ors

Respondents

Ms. Meenaz Kakalia for Petitioner

Mr.Y.R.Mishra a/w Mr.N.R.Prajapati for Respondent Union of India Mr.S.L.Babar AGP for State-
Respondent no.2

CORAM : SHANTANU S.KEMKAR AND G.S.KULKARNI, JJ

Date: 5 DECEMBER 2017

P.C.

1. Heard learned counsel for the parties. With consent finally disposed of.
2. The Petitioner who is a 13 year old girl and a victim of alleged rape and sexual abuse has preferred this writ petition seeking direction for allowing her to terminate the pregnancy which is of more than 25 weeks.
3. On 30.11.2017 while issuing notice to the respondents, this Court constituted a Committee of Experts of K.E.M.Hospital Mumbai to medically examine the petitioner and submit a report. As per directions of this Court the Expert Committee consisting of (1) Dr. Avinash N.Supe, Director (Medical Education and Major Hospitals) and Dean (G&K) Chairman (2)

Dr.Ajita Nayak, Professor, Psychiatry, K.E.M.Hospital (3) Dr.Amar Pazare, Professor and H.O.D. Medicine, K.E.M.Hospital (4) Dr.Indrani Hemantkumar Chincholi, Professor and H.O.D.Anesthesia K.E.M.Hospital (5) Dr.Y.S.Nandanwar, ExProfessor and H.O.D. Obstetrics & Gynecology, L.T.M.M.C and L.T.M.G.Hospital (6) Dr.Padmaja Samant, Addl. Professor, and Unit Head, Obstetrics & Gynecology, K.E.M.Hospital (7) Dr.Hemangini Thakkar, Addl. Professor, Radiology K.E.M. Hospital and (8) Dr.Ruchi Nanavati Prof & H.O.D. Neonatology, K.E.M.Hospital has been constituted by the said hospital. The Petitioner appeared before the said Medical Board. The Medical Board on examination has submitted its opinion. The salient features of the said opinion reads thus:

- “(a) On the other hand, pregnancy at this stage (especially with this patient's challenges) is known to cause severe detrimental effects on the physical and psychological health and emotional well being of a young girl.
- (b) Continuation of pregnancy may pose additional risk of conditions like pregnancy induced hypertension. (Known to occur in very young pregnant patients) It is the 2nd most common cause of maternal mortality.
- (c) The patient has also been anaemic and was transfused blood to correct the same. Anemia is another important cause of maternal mortality.

Thus, we submit that continuation of pregnancy is likely to cause severe physical and mental consequences for the patient.

- (d) The mental trauma of childbirth will be the same regardless of whether the pregnancy is continued but the guilt of abandoning a fullygrown neonate will be additional in case of continuation of pregnancy.”

4. The said opinion is taken on record and marked as Exhibit 'X' for identification. The said report/opinion is suggestive of the fact that the termination of the pregnancy at this stage of 25 weeks and three days or delivery at term will have equal risk to the mother. It also suggests that it would be in the interest of the (patient) petitioner that the pregnancy is to be terminated at it may pose danger to the risk on conditions like hypertension and cause of maternal mortality.
5. Considering the age of the petitioner which is only 13 years, the trauma she has suffered because of sexual abuse and the agony she is going through at present and above all the report of the Medical Board constituted by this Court, and also having due regard to the fundamental rights conferred under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the petitioner to undergo the medical termination of pregnancy under the provisions of the Medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery.
6. Accordingly, we allow the petition and direct the petitioner to remain present in the said hospital

tomorrow i.e. 6.12.2017 so that the termination of pregnancy can be carried out within a day or two by the expert team.

7. The learned AGP is directed to apprise the Dean of the said Hospital so that appropriate arrangements for the termination of the pregnancy can be done.
8. In addition, we direct the Law Officer of the Municipal Corporation of Greater Mumbai to inform the said Hospital about passing of this order.
9. Parties to act on an authenticated copy of this order.
10. With aforesaid directions, petition is allowed in aforesaid terms.
11. We are passing this order keeping in view the law laid down by the Supreme Court in case of MURUGAN NAYAKKAR VS UNION OF INDIA & ORS decided on 6.9.2017 in Writ Petition (s) Civil No. (s) 749 of 2017.

(G.S.KULKARNI, J) (SHANTANU.S.KEMKAR,J)

Savita Ravi Garud vs Union of India and Anr W.P No. 14261 of 2018

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE
JURISDICTION

WRIT PETITION STAMP NO.14261 OF 2018

Savita Ravi Garud, Through her mother and naturalguardian

SunitaRaviGarud

..Petitioner Vs.

Union of India & Anr.

..Respondents

Ms.Meenaz Kakalia for the petitioner.

Ms.Purnima Awasthi with Mr.Anand Singh for the respondent nos.1 and 3. Mr.Sandip Babar AGP for the State.

Mr.G.S.Godbole with Ms.Vidya Gharpure, Sharmila Modale, Madhuri More for the Corporation.

Dr.Vidya Thakur, Dr.Meena Savjam, Dr. Hemangi Worke, Dr.Gaurav Desai, Dr.Durga Valvi, KEM Hospital present in Court.

Mrs.Sunit R. Garud, mother of the petitioner present in the Court.

P.C. :

CORAM : A.K. MENON &

SMT.BHARATI H. DANGRE, JJ. (VACATION COURT)

DATED : 9TH MAY,2018.

1. Heard. The respondents waive service. By consent of the parties the petition is taken up for finalhearing.
2. By this petition, the petitioner, through her mother and natural legal guardian seeks permission

to medically terminate the pregnancy which has passed the 20 weeks contemplated in the Medical Termination of Pregnancy Act, 1971 (Act). The petitioner is present stated to be of 16 years of age and a victim of sexual assault and rape. It is stated that the petitioner has suffered immense mental and physical anguish as a result and seeks directions of the Court to allow her terminate her pregnancy to protect her health.

3. On 4th May, 2018 a Division Bench of this Court constituted a Committee of Experts to form a Medical Board at Rajawadi Hospital under the Dean and experts in the field of Gynecology, Neurology, Paediatrics, Psychology, Radiology and other experts to examine the petitioner and give its opinion whether it would be safe to terminate pregnancy of the petitioner. The Dean Rajawadi Hospital has pursuant to the order passed by this Court on 4th May, 2018 constituted a Board consisting of eight doctors Dr. Vidya V. Thakur, Dr. Sumedha Tiwari, Dr. Kiran Mhatre, Dr. Kanchan Chaudhari, Dr. Prakash Trivedi, Dr. Soumil Trivedi, Dr. Manish Doshi and Dr. Maya Wankhede.
4. The Board has since submitted a report dated 7th May, 2018 whereby the general medical condition of patient has been found to be conducive to carry out the procedure. She is able to go through the procedure of medical termination. The examination included General medical examination as also examination by Radiologist, Psychiatrist, Gynecologist, Pediatrician and Anesthetist. The opinion is taken on record and marked "X" for identification. The opinion of the doctors and conclusions reached by the Panel of doctors are as follows:
 1. *Current pregnancy is about 25 weeks by clinical and Sonographic evaluation.*
 2. *In our opinion of board, considering the age of the patient (16 years) continuation of pregnancy (24.1 weeks) can lead to complications including mortality and is detrimental to the overall health of the patient.*
 3. *The mental trauma of child birth will be the same regardless of whether the pregnancy is continued but the guilt of the abandoning a fully grown neonate will be additional in case of continuation of pregnancy.*
5. On 7th May, 2018 when this matter was listed before us, the petitioner's mother seemed hesitant at one stage and was unsure as to whether or not pregnancy is to be terminated. However, after consulting the panel of doctors and given the opinion that continuation of pregnancy can lead to complications including mortality and is detrimental to the overall health of the patient, she has since expressed the desire to proceed with termination of pregnancy. We have also interacted with the mother of victim during the course of hearing and she has stated that her hesitation was only caused due to different reactions of other family members. However, she is today firmly of the opinion that the pregnancy is required to be terminated. The Board is clearly of the view that pregnancy can be terminated as per patient and family members' request.
6. Today, at the hearing Mr. Godbole, learned counsel appearing on behalf of respondent no. 4-corporation, which manages the Rajawadi Hospital has stated that the investigation has also revealed that the consequences of the procedure could be that the foetus may not survive. It is

further submitted on behalf of the corporation that rather than the procedure being carried out at Rajawadi Hospital, Ghatkopar it would be appropriate that procedure is conducted at K.E.M. Hospital, Parel, in view of the fact that K.E.M. Hospital has much better facilities including those that may be required in the event of any emergency. In addition, it is submitted that the team of doctors at K.E.M. Hospital is much larger and more accessible in case of emergency when compared to the Rajawadi Hospital.

7. In the circumstances, having considered all facts and in particular the fact that the petitioner is of a tender age of 16 years and likelihood of mental and physical anguish and trauma she continues to go through and her fundamental right under Article 21 of the Constitution of India to live a life with dignity and in the light of the opinion that continuation of the pregnancy at this tender age of 16 years may lead to maternal mortality, it is appropriate that this Court permits medical termination of pregnancy. In this behalf this Court has in Writ Petition 13228 of 2017 passed a similar order following the decision of the Supreme Court in cases of Murugan Nayakkar Vs. Union of India Writ Petition (Civil) No.749 of 2017.
8. In the circumstances, we allow the petitioner to medically terminate her pregnancy. Considering the fact that time is of essence and any further delay would increase the risk to the petitioner, the Corporation will ensure that the petitioner is transferred from Rajawadi Hospital to K.E.M. Hospital at the earliest possible opportunity and preferably by the end of day today i.e. 9th May, 2018 so that K.E.M. Hospital could conduct all preliminary and precautionary tests required as is done in any normal case of medical termination of pregnancy.
9. The entire team of doctors comprising the Board of Rajawadi Hospital shall be available for consultation with the team at K.E.M. Hospital. In conclusion, we make it clear that all necessary precaution be followed in terms of the Act and Rules framed thereunder and shall be observed by the K.E.M. Hospital. The Dean of K.E.M. Hospital shall ensure that all necessary arrangements are made forthwith to avoid any procedure delay for commencement which in any case should commence preferably tomorrow i.e. by 10th May, 2018.
10. The Law Officer, Municipal Corporation shall also inform the hospitals in question about this order to ensure timely compliance.
11. All concerned to act on an authenticated copy of this order. Meanwhile Mr. Godbol states that he will ensure that all necessary action will be taken by the hospitals concerned, without awaiting an authenticated copy of this order.
12. The petition is allowed in the aforesaid terms and is disposed off accordingly.
13. The Report dated 7th May, 2018 shall be retained in the Registry in a sealed cover.

(SMT.BHARATI.H.DANGRE,J.)

(A.K.MENON,J.)

Rupali Chetan Kumbhar vs Union of India and Ors W.P No. 2020 of 2018

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL

APPELLATE JURISDICTION

WRIT PETITION NO. 2020 OF 2018

Rupali Chetan Kumbhar
Union of India and Ors...Petitioner Vs.
Respondents

Ms. Minaz Kakalia for the Petitioner.

Mr. Sandeep Babar, AGP for respondent no. 2 State.

Mrs. Purnima Awasthi a/w Mr. Ashok Varma for respondent nos. 1 and 3 Union of India.

CORAM: SHANTANU KEMKAR &
M.S. KARNIK, JJ.

DATE: MARCH 01, 2018

P.C.:

1. Petitioner Rupali Chetan Kumbhar has approached this court under Article 226 of the Constitution of India seeking direction to the first respondent to produce a report of the appropriate committee which may be constituted by this court for examination of the petitioner and for submitting its report as to whether the petitioner can be allowed to get the pregnancy terminated.

2. According to the petitioner, pregnancy has gone upto 24 weeks which is beyond the permissible period of 20 weeks, in the circumstances, petitioner has approached this court.
3. On 21.2.2018 while issuing notice to the respondents, this court has directed constitution of the committee consisting of various experts from Sir JJ Group of Hospitals, Mumbai. The said Committee after examining the medical reports submitted by the petitioner and after conducting various tests upon her, submitted its report. The relevant portion of the report of the said expert committee reads thus:

“THE COMMITTEE AFTER EXAMINATION AND CAREFUL STUDY OF MULTIPLE SONOGRAPHY REPORTS, HAS CONFIRMED THAT THE FETUS HAS A NEUROLOGICAL ABNORMALITY IN THE FORM OF:

1. *ABSENCE OF CAVUM SEPTUM PALLIDUM*
2. *SQUARING OF FRONTAL HORNS OF BOTH LATERAL VENTRICLES*
3. *AGENESIS OF CORPUS CALLOSUM*
4. *COLPOCEPHALY*
5. *SEPTO OPTIC DYSPLASIA CANNOT BE RULED OUT. THIS CAN RESULT IN:*
 1. *DELAYED DEVELOPMENT.*
 2. *RESISTANT EPILEPSY*
 3. *INTELLECTUAL IMPAIRMENT*
 4. *PHYSIC CHOSIS*
 5. *VISUAL DEFECTS*
 6. *SPASTICITY/CEREBRAL PALSY*
 7. *AUTISM/ADHD/DYSLEXIA*

SUCH CASES ALSO MAY BE ASSOCIATED WITH:

1. *MIGRATIONAL DISORDERS*
2. *PVL*
3. *INTRAVENTRICULAR HAEMORRHAGE*
4. *MICROCEPHALY OR HYDROCEPHALUS*
5. *VARIOUS SYNDROMES LIKE AIRCADES SYNDROME AND OTHERS.*

THUS THE CONDITION OF FETUS FULFILL THE CRITERIA OF “SUBSTANTIAL RISK OF SERIOUS PHYSICAL HANDICAP.” THE PREGNANCY HAS ADVANCED UPTO 24 WEEKS AND IS BEYOND 20 WEEKS CUT OFF OF MEDICAL TERMINATION OF PREGNANCY ACT. HENCE, SHE

HAS APPROACHED THE HONOURABLE COURT FOR TERMINATION OF PREGNANCY.

IF THE HONORABLE COURT PERMITS PREGNANCY CAN BE TERMINATED AS DESIRED BY PREGNANT WOMAN. THE RISK OF TERMINATION OF PREGNANCY IS NOT GOING TO BE MORE THAN THAT OF NORMAL LABOUR.”

4. We have gone through the said opinion which includes opinion of the various expert doctors including Dr. Ashok Anand, Professor and Head, Dept of OBGY, GGMC, Mumbai, Dr. V.P. Kale, Professor and Head, Dept of Psychiatry, GGMC, Mumbai, Dr. Shilpa Domkundwar, Professor and Head, Dept of Radiology, GGMC, Mumbai, Dr. Bela Varma, Professor and Head, Dept of Pediatric, GGMC, Mumbai, Dr. Kamlesh Jagyasi, Dr. Kamlesh Jagyasi, Professor and Head, Dept of Neurology, GGMC, Mumbai. It appears that the Committee has reached the conclusion that there would be substantial risk of serious physical handicap.
5. Having regard to the aforesaid, it is very difficult for us to refuse permission to the petitioner to undergo the medical termination of the pregnancy. It is certain that if the petitioner is allowed to give birth to foetus, there is substantial risk of serious physical handicap.
6. In view of the above peculiar circumstances and having due regard to the fundamental right conferred on the petitioner under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the petitioner to undergo the medical termination of pregnancy under the provisions of the medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery.
7. The learned AGP as also the learned counsel for the Union of India have not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.
8. We further direct that the termination of the petitioner's pregnancy to be performed within three days by the expert doctors of Sir, J.J. Group of Hospital, Mumbai where she has to undergo medical check up.
9. The termination of the pregnancy will be supervised by the Committee/Medical Board constituted by this court which shall maintain the complete report of the procedure which would be performed on the petitioner at the time of termination of the pregnancy.
10. We also make it clear that in the event of any problem in connection with the medical termination of the pregnancy, the doctors of the Medical Board shall have immunity in law.
11. Petitioner shall bear the cost of the operation and other expenses.
12. With the aforesaid directions, petition is disposed of.
13. Parties to act on authenticated copy of this order.

(M.S.KARNIK,J.) (SHANTANU KEMKAR,J.)

Nandini Tushar Rawool vs Union of India and Ors W.P No. 8313 of 2018

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL
APPELLATE JURISDICTION

Writ Petition NO. 8313 OF 2018

Nandini Tushar Rawool ...Petitioner

Versus

The Union Of India Thr. The Secretary And Ors ...Respondents

Ms. Meenaz Kakalia i/b. Kranti L.C., for the Petitioner.

Mr. A. B. Vagyan, Government Pleader with Mr. V. N. Sagare, AGP for the State Respondent no. 2.

Mrs. Poornima Awasthi, for Respondent Nos. 1 and 3 Union of India. Dr. Padmaja Samant from KEM Hospital present.

CORAM : NARESH H. PATIL, ACTING CJ &

G. S. KULKARNI, JJ.

DATE : 14th August, 2018

P.C.:

1. The petitioner Nandini Tushar Rawool aged 29 years who has a twenty six weeks pregnancy, has approached this Court by this petition under Article 226 of the Constitution seeking direction to the respondents to allow her to undergo medical termination of her pregnancy. The petitioner has annexed to the petition an ultrasound sonography report dated 6 July 2018 which makes the following remarks:

“Fetal RVOT and LVOT could not be seen optimally. Fetal right atrium appears dilated.”

2. The petitioner was also examined by Dr. Shrirang Dokhale who had conducted 2D Echo examination recorded a finding which are suggestive of “complex congenital heart disease of the fetus.”
3. By an order dated 8 August 2018 we directed the Dean of KEM Hospital to constitute a committee of experts to examine the petitioner and to submit a report to the Court. Accordingly, the learned Dean has constituted a Medical Board consisting of the following experts in the different faculties:
 - “1. Dr. Avinash N. Supe, Director (Medical Education & Major Hospitals) & Dean (G & K) Chairman.
 2. Dr. Padmaja Samant, Addl. Professor and Unit Head, Obstetrics & Gynecology, Dr. Himangi S. Warke, Associate Professor, Obstetrics & Gynecology,
 3. Dr. Shubhangi Parkar, Professor & HOD, Psychiatry,
 4. Dr. Anjali Rajadhyaksha, Professor, Medicine,
 5. Dr. R.D. Patel, Professor and acting HOD, Anesthesia,
 6. Dr. Hemangini Thakkar, Additional Professor, Radiology,
 7. Dr. Rucha Nanavati, Professor and Head Neonatology,
 8. Dr. Dheeraj More, Assistant Professor Cardiology,
 9. Dr. Dwarkanath Kulkarni, Professor, Cardiovascular Surgery.”
4. In pursuance to our order, a report of the Medical Board dated 10 August 2018 is placed on record. The petitioner was examined by all the members of the board. The members of the board have recorded the following findings:
 - “4. Ultrasonographic and echocardiographic diagnosis: By ultrasound of 09/08/2018 Mrs. Nandini Rawool is 26 weeks pregnant. The fetus has tetralogy of Fallot with ventricular septal defect, small right ventricular outflow tract, double superior vena cava and two vessel cord.
5. Obstetric examination: On clinical examination of Mrs. Nandini Rawool, the uterus is about 28 weeks size, and fetal heart sounds can be heard. Uterus is relaxed.
6. Psychiatric evaluation: Mrs. Nandini Rawool is emotionally stable at present and is psychiatrically fit to take her health related decisions. She is well supported by her husband.
7. Medical examination: Mrs. Nandini Rawool has no clinically significant medical problem.
8. Pre anesthetic assessment: Mrs. Nandini Rawool is fit for general/regional anesthesia.
9. Cardiology opinion: This fetal condition means that the baby may require early palliative surgery followed by definitive surgery. The long term survival of the baby is unlikely to be like an otherwise healthy baby, but the condition is not likely to be fatal if managed properly.”

(emphasis supplied)

5. The medical board on the above findings has recorded the following conclusions:

“Based on the above findings, the board has concluded that:

1. Current pregnancy is about 26 weeks by patient's clinical & sonographic evaluation.
2. The diagnosis of tetralogy of fallot with ventricular septal defect, small right ventricular outflow tract, double superior venacava and two vessel cord has been made based on ultrasonography and echocardiography.
3. The fetal condition indicates need for early palliative surgery followed by definitive surgery. The condition is not fatal but long term survival of the baby is not likely to be like that of an otherwise healthy baby.
4. A full term mature baby may survive the surgery better rather than a pretermone.
5. There is no physical risk to the mother, due to continuation or termination of pregnancy.
6. If the pregnancy is terminated At 26 weeks, the baby may be born Alive. The neonatological guidelines allow nonresuscitation in only 2 conditions, anencephaly and trisomy 13. This means that the preterm neonate will be resuscitated and may live for variable length of time; The anomalies are at present seen in the intrauterine fetus and may be less or more on assessment after birth. The management may be modified accordingly. The doctors will face an ethical dilemma in deciding for or against intervention. If the neonate dies due to problems of prematurity, the death will have to be reported to the authorities as per current procedural guidelines. This will amount to deliberate preterm induction of avoidable cause..

7. Maternal risks:

- The petitioner Mrs. Nandini Rawool is in a physically and mentally fit condition to undergo procedure of induction. But the couple has to know certain risks associated with deliberate medical interventions.
- Uninduced natural labour is more likely to have smooth progress and fewer complications like excessive contraction, need for surgical intervention, trauma, bleeding, future problems that ensue with scarred uterus. Though the petitioner and her husband are at present distressed with the thought of the near certain perinatal fatality, they both have to clearly understand these maternal risks mentioned above.
- Mental anguish due to natural causes is part of life. Pregnancy out of sexual assault (for which this board recommended termination in the past), causes the stigma and profound psychological effect on a growing adolescent. That is a unique situation.

- Inconvenience of looking after one's own challenged child as an indication for termination beyond viability is akin to reproductive materialism. The board is concerned about promotion of such practice, outside the legal sanction of the country's laws. Importantly only sympathy for the mother cannot be basis of the opinion.
 - * Till the law is modified, the onus of such promotion/practice lies with one board of experts or a hospital and that is medicolegally inappropriate.
 - * Hence weighing the maternal health and neonatal problems, the board is of the opinion that the pregnancy may be continued and may take its own course.
 - * Psychological counseling is recommended. Emotional support and counseling has taken in numerous mothers through such testing times.
 - * The board also requests the court to grant immunity from any medico legal liability due to giving opinion as asked by the honourable court." (Emphasis added)
6. The learned counsel for the petitioner would submit that the board has confirmed that the fetus has a complex congenital heart disease and if the child is born, it is unlikely to be a healthy baby. It is her submission that in such a situation, the petitioner is entitled for the relief of medical termination of pregnancy. Learned counsel for the petitioner has placed reliance on the decision of the supreme court in "*Tapasya Umesh Pisal vs. Union of India & ors.*"¹, To submit that the facts of the present case are similar to the facts in the said case where the supreme court permitted medical termination of pregnancy. The learned counsel for the petitioner has also placed reliance on the decision of the division bench of this court in *Shaikh Ayesha Khatoon vs. Union of India & ors*² to submit that section 3(2)(b)(ii) if read in conjunction of section 5(1) of the medical termination of pregnancy Act, 1971, then the relief ought to be granted to the petitioner.
 7. On the other hand, the learned Government Pleader has supported the finding as contained in the report of the medical board. The learned Government Pleader contends that the report clearly observes that the condition of fetus is not likely to be fatal if managed properly if early palliative surgery followed by definitive surgery is undertaken. The learned Government Pleader would refer to the observations of the board in paragraphs 3 and 6 wherein the board has noted that the condition of the fetus is not fatal but long term survival of the baby is not likely to be like that of another wise healthy baby.
 8. Dr. Padmaja Samant, Additional Professor and Unit Head, Obstetrics & Gynecology at the request of the Court has assisted the Court. Dr. Samant has appraised and explained to the Court the various findings as recorded in the report of the medical board. When we asked for

1. Writ Petition (Civil) No.635 of 2017 Order dt.10.8.2017.

2. Writ Petition (St) No.36727 of 2017 order dt.9.1.2018.

a clarification as regards the findings as recorded in paragraph 9 of the report which pertains to the cardiology opinion and the conclusion in paragraph 3 of the report as noted by the us above, Dr.Samant has explained to us that even if the pregnancy is terminated at this stage, the baby would be born alive. She explained that there is no harm for the petitioner to have a regular delivery of the baby as explained in the report and on delivery, the baby would be required to undergo early palliative surgery followed by definite surgery. She explained to us the cardiology opinion which records that “long term survival of baby is unlikely to be like another wise healthy baby”, would mean that the child after successful surgery would not be like a normal child in the sense, the child would not be in a position to under take running or climbing and except for these restrictions the child may have a normal life on a successful surgery. Dr. Samantal so highlighted the findings of the committee in paragraph 6 and the maternal risk which are pointed out in paragraph 7 of the report.

9. We have heard the learned Counsel for the parties. We have perused the record and there port of the medical board.
10. The Medical Board has recorded findings that the condition of fetus is not fatal, and the child when born would require early palliative surgery followed by definite surgery. It is further recorded that the long term survival of the baby is unlikely to be like an otherwise healthy baby, but the condition is not likely to be fatal if managed properly. Thus, in our opinion, this is not a case where the medical opinion on the surgery is such that the surgery would definitely and conclusively lead to child mortality. The findings in paragraph 6 of the conclusion as noted by us above, also stare at us. In the circumstances, this is not a case where we can permit medical termination of pregnancy.
11. The reliance on behalf of the petitioner on the orders of the Supreme Court in *Tapasya Umesh Pisal vs. Union of India & Ors.* (supra) would also not assist the petitioner. That was a case where the fetus was diagnosed as having hypoplastic right heart with tricuspid and pulmonary atresia with small size pulmonary arteries. The opinion of the medical board was that in such situation surgeries on the fetus have been reported to carry high morbidity and mortality. It was also reported that inspite of the surgeries, such children do not achieve normal oxygen level and would remain physically incapacitated and the life span of these children even after corrective surgeries is limited as described in medical literature. It was also a case of isolated complex congenital heart disease with increased morbidity and mortality post delivery. The radiologist had also reported a complete absence of right ventricle and pulmonary and tricuspid valve atresia. The Supreme Court also recorded the opinion of an eminent surgeon who stated that most of these children do not live till the adult life, as also their life is precarious because of the problems resulting from low oxygenation in the body. It was also observed by one of the Cardiac Surgeon that there is a near certain chance of severe handicap or sudden death of the baby after birth. It is in these circumstances, the Supreme Court had permitted the medical termination of pregnancy. Definitely, the facts in the present case are not such.

12. In the facts of the present case, the observations of the Division Bench in *Abaikh Ayesha Khatoon vs. Union of India & Ors* (supra) in paragraphs 10 and 11 of the decision would also not assist the petitioner. It is clear that there is no threat to the life of the petitioner as observed by the medical board.
13. For the above reasons, we cannot discard the opinion of the medical board. The findings of the medical board including the last two lines which pertain to the medico legal immunity stand accepted in totality for all the members of the board as also for Dr. Samant in her explanation and assistance to the Court.
14. We express our appreciation to the valuable assistance provided by Dr. Padmaja Samant.
15. The prayer of the petitioner to permit medical termination of pregnancy, thus cannot be granted. We find no merit in the petition. It is accordingly rejected. No costs.

G.S.KULKARNI, J.

ACTING CHIEF JUSTICE

Yashika Bakrishna Berde vs Union of India and Ors W.P No. 3694 of 2018

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL
APPELLATE JURISDICTION

WRIT PETITION NO.3694 OF 2019

Ms.YashikaBalkrishnaBerde

...Petitioner

Vs

Union of India through the Secretary and Ors.

... Respondents

Ms.Neha Philip for the Petitioner.

Ms.Anusha P. Amin for Respondent Nos.1 and 3.

Mrs.M.P. Thakur, AGP for State.

CORAM : S. C. DHARMADHIKARI & B.P.COLABAWALLA, JJ.

DATE: MARCH 27,2019

P.C.:

1. The petitioner before us has filed this petition seeking a direction to allow her to terminate the pregnancy through the mechanism under the Medical Termination of Pregnancy Act, 1971.
2. It is claimed that Section 3 of this Act allows termination of pregnancy by registered medical practitioners even if the length thereof exceeds 20weeks.
3. Presently the petitioner is in the 22nd week of her pregnancy and she says that the medical opinion is that the continuance of pregnancy would involve grave injury to the mental health of the petitioner.

4. The projection before us that the mental condition of the petitioner is not such as would enable her to continue with the pregnancy. Her mental health is not good and opinion of the private medical practitioner is relied upon in that behalf.
5. In the morning session, we indicated to the petitioner's advocate that given the nature of the opinion of the private medical practitioner, it cannot be said that her mental health is such that continuance of pregnancy would involve a risk to her mental condition. That is not a conclusive opinion. Yet, the petitioner's advocate, on instructions, maintains that the petitioner is not in a position to continue with the pregnancy as she would be required to be under medication throughout and it would also have some ill effect.
6. In the circumstances, strictly to examine her mental health, there is a request to constitute a Medical Board.
7. In the above facts and circumstances and peculiar to this petitioner, we request the Dean, Sir J.J. Group of Hospitals, Mumbai to constitute a Medical Board so as to examine the petitioner with regard to her mental health and submit a report to this Court.
8. The learned AGP Mrs. Thakur says that she will communicate this order to the Superintendent/Dean of the above hospital and ensure that report with regard to the mental health of the petitioner will be forwarded to this Court on next date.
9. We post this petition on 1st April, 2019.

(B.P. COLABAWALLA, J.)

(S.C. DHARMADHIKARI, J.)

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO.3694 OF 2019

Ms.Yashika Balkrishna Berde...

Petitioner

Vs

Union of India through the Secretary and Ors.

...Respondents

Ms.Neha Philip for the Petitioner.

Ms.Anusha P. Amin for Respondent Nos.1 and 3.

Mrs.M.P. Thakur, AGP for State.

CORAM : S. C. DHARMADHIKARI & B.P.COLABAWALLA, JJ.

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9. We post this petition on 1st April, 2019.

(B.P.COLABAWALLA, J.)

(S.C.DHARMADHIKARI, J.)

Zarka vs Union of India and Ors W.P No. 1447 of 2019

IN THE HIGH COURT OF
JUDICATURE AT BOMBAY CIVIL
APPELLATE JURISDICTION
WRIT PETITION NO. 1447 OF 2019

Zarka Khan

... Petitioner

V/s.

Union of India and Ors.

... Respondents

Ms. Neha Philip for the Petitioner.

Ms. Anamika Malhotra for Respondent Nos. 1 and 3. Mr. N.C. Halimbe, AGP for the Respondent.

CORAM : B.P.DHARMADHIKARI, & REVATI MOHITE DERE, JJ.

DATE: 06th FEBRUARY, 2019

P.C.:

1. Heard respective Counsel. Perused report received from Sir J.J. Hospital along with forwarded letter dated 06.02.2019.
2. Envelop containing the forwarding letter and Report has opened in the Court. Perusal of report shows that eight experts have examined Petitioner and fetus. They have found that fetus suffers very serious neurological and other abnormalities in the form of Acrania, Kyphoscoliosis, Omphalocele and Congenital Diaphragmatic Hernia. The Experts therefore, certified that condition of fetus fulfills the criteria of “**Substantial risk of serious physical Handicap**”. They have taken note of fact that pregnancy has advanced to 26 weeks and hence, permission of Court is necessary. Petitioner before committee had reiterated her desire to terminate it. Even today, learned Counsel for Petitioner communicates the same desire.

3. In this situation, accepting the report, we permit Petitioner to terminate the pregnancy. She shall report at Sir J.J. Hospital by 12.00 noon on 08.02.2019 where necessary procedure shall be undertaken at the earliest.
4. Parties to act upon an authenticated copy of this order.

(REVATI MOHITE DERE, J.)

(B.P.DHARMADHIKARI, J.)

Coercive Sterilization

Smt. Komal Bai vs. State of Madhya Pradesh and Ors. W.P No. 3634/2016

Presented on 13-11-2016
BY SHANU KANU
Presentation Assistant

②

SEAL OF THE HIGH COURT
JABALPUR

IN THE HIGH COURT OF MADHYAPRADESH
BENCH AT INDORE
WRIT PETITION No. 3634/2016

AFFIXED PETITIONER'S FEE

Smt. Komal bai W/o lakhan rajput
Age 26 year, resident Village Aalaniya,
Tehsil Kalapipal District shajapur.

VERSUS

RESPONDENTS:

1. State of M.P. Through the Principal Secretary, Health & Family Welfare Department, Government of Madhya Pradesh, Vallanh Bhawan, Arera Hills, Bhopal (M.P.)

2. Medical Superintendent, CHC, kalpibal, Shajapur, (M.P.)

3. Chief Medical Health Officer Shajapur (M.P.)

4. Collector Shajapur District Shajapur(M.P.)

Office of the
Advocate General
M.P. High Court Bench
INDORE

FOR COPYING FEES ONLY
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WRIT PETITION**UNDER ARTICLE 226 OF THE CONSTITUTION OF INDIA**

1. Particulars of the cause / order against which the petition is made:
 - (1) Date of Order / Notification / Circular / Policy / Decision etc : Nil
 - (2) Passed in (Case or File Number): Nil
 - (3) Passed by (Name and designation of the Court, Authority, Tribunal etc.): Nil
 - (4) **Subject-matter in brief:**

In violation of the Petitioner's fundamental right to life, to health, to equality, and to dignity, petitioner got married to Lakhan Rajput at the age of 19. After 1 year she gets pregnant and first child was Arun delivered at

Shamr

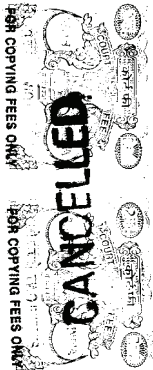
ANNEXURE - C
HIGH COURT OF MADHYA PRADESH

CASE NO.....OF 20.....

ORDER SHEET (CONTINUATION)



DATE & S. NO. OF THE ORDER	ORDER	- 1 -
	<p><u>Writ Petition No.3634/2016</u></p> <p><u>05/07/2017</u></p> <p>Ms. Shanno Shagufta Khan, learned counsel for the petitioner.</p> <p>Mr. Peyush Jain, learned counsel for the respondent/State.</p> <p>The petitioner before this Court has filed this present petition for issuance of an appropriate writ, order or direction directing the respondents to grant compensation to the petitioner on account of failure of Family Planning Operation.</p> <p>The petitioner's contention is that the petitioner on 24/08/2011 has undergone Sterilization Operation at CHC, Kalapipal, Shajapur which is a hospital of State of Madhya Pradesh. The petitioner has further stated that in spite of the operation conducted by the State Government, she became pregnant and later on, on account of further complication she delivered a child through Cesarean Operation.</p> <p>Learned counsel for the petitioner has straightaway drawn the attention of this Court towards paragraph No.5.7 of the writ petition which refers to a scheme known as "Family Planning Indemnity Scheme" and the scheme provides for payment of compensation of Rs.30,000/- in case of incapacity and in the case of post-operative complications. Learned counsel for the petitioner has vehemently argued before this Court that the petitioner has taken all due care and caution as advised by the Doctor and the operation resulted in failure.</p>	





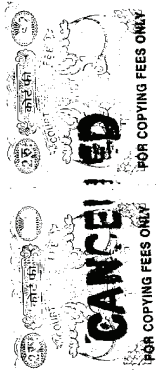
ANNEXURE - C

HIGH COURT OF MADHYA PRADESH

CASE NO..... OF 20.....

ORDER SHEET (CONTINUATION)

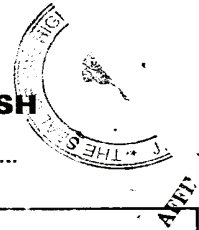
DATE & NO. OF THE ORDER	INDORE	ORDER	- 2 -
		<p>On the other hand, a reply has been filed in the matter and the respondents have stated that the petitioner is not entitled for any relief of whatsoever kind and the petitioner has not followed the advise of the Doctor and has not taken post-operative care. Reliance has been placed upon a judgment delivered by the apex Court in the case of State of Punjab Vs. Shiv Ram reported in IV (2005) CPJ 14 (SC) (Annex.-R/2) and his contention is that in light of the aforesaid judgment, the question of payment of compensation to the petitioner does not arise.</p> <p>Heard learned counsel for the parties at length and perused the record.</p> <p>In the present case, the undisputed facts reveal that the petitioner has undergone Sterilization Operation on 24/08/2011. The undisputed facts also reveal that the petitioner has later on delivered a child through Cesarean Operation. No document has been filed in respect of post-operative care / advise given to the petitioner by the Doctor at the time of operation.</p> <p>Government of India in order to ensure proper implementation of Family Planning Scheme has issued a manual for Family Planning Operations and has framed a scheme known as Family Planning Indemnity Scheme. As per the scheme and keeping in view the directions of the Hon'ble Supreme Court in the case of Ramakant Rai & Anr. Vs. Union of India & Ors. passed in Writ Petition (Civil) No.209/2003, the Union of India has laid down the norms and in case of death a sum of Rs.1 Lac has to be</p>	



ANNEXURE - C
HIGH COURT OF MADHYA PRADESH

CASE NO.....OF 20.....

ORDER SHEET (CONTINUATION)



DATE & S. NO. OF THE ORDER	ORDER
	- 3 -
	<p>given and a sum of Rs.30,000/- in case of incapacity and Rs.20,000/- in case of post-operative complications. Relevant extract of the scheme in paragraphs No.1.1.9 reads as under:-</p> <p>"1.1 Directives of Hon'ble Supreme Court:</p> <p>9. <i>The Union of India shall also lay down the norms of compensation which should be followed uniformly by all the states. For the time being until the Union the Union Government formulates the norms of compensation, the States shall follow the practice of the State of Andhra Pradesh and shall pay Rs.1 Lakh in case of death of the patient sterilized, Rs 30,000/- in case of incapacity and in the case of post-operative complications, the actual cost of treatment being limited to the sum of Rs.20,000/-."</i></p> <p>The scheme is operational from 01/10/2013. In light of the scheme as the factum of operation and delivery of a child has not been denied, there is no documents on record to establish that the petitioner was directed to take post-operative care, this Court is of the opinion that the petitioner is entitled for a sum of Rs.30,000/- as per the Indemnity Scheme.</p> <p>Learned Government Advocate has drawn the attention of this Court towards Annex.-R/1 which is a literature relating to failure of female sterilization and his contention is that there is no such method which provides for 100% guarantee in case of sterilization operations.</p> <p>This Court has carefully gone through the aforesaid document, however, the aforesaid document will not supersede the Indemnity Scheme framed by the Government of India. Learned counsel for the State Government has also placed reliance upon a judgment of the Hon'ble Supreme Court in the</p>



ANNEXURE - C
HIGH COURT OF MADHYA PRADESH

CASE NO.....OF 20.....

ORDER SHEET (CONTINUATION)

DATE & S.
NO. OF THE
ORDER

INDORE

ORDER

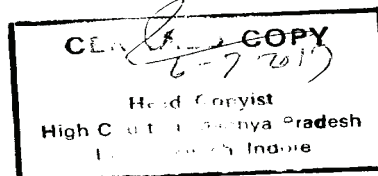
- 4 -

case of **State of Punjab Vs. Shiv Ram (Supra)** and his contention is that unless and until it is established that there was negligence on the part of the Surgeon, no compensation can be awarded.

This Court has once again carefully gone through the aforesaid judgment and is of the opinion that the judgment is of the year 2005, thereafter, the Government of India in the year 2013 has framed a scheme based upon the subsequent judgment delivered in the case of **State of Punjab Vs. Shiv Ram (Supra)** dated 01/03/2005 and therefore, in the considered opinion of this Court, the judgment relied upon is again of no help to the State Government.

Resultantly, the writ petition stands allowed with a direction to the Chief Medical and Health Officer, Shajapur to pay a sum of Rs.30,000/- to the petitioner within a period of 60 days from the date of receipt of certified copy of this order. In case, the amount is not paid within 30 days to the petitioner, the same shall carry interest @ 12.5% per annum from 24/08/2011 till the amount is actually paid to the petitioner.

Certified Copy as per rules.



(S. C. SHARMA)
JUDGE



Devika Biswas Vs. Union of India and Ors. Supreme Court W.P. (C) 95/2012

IN THE SUPREME COURT OF INDIA CIVIL ORIGINAL
JURISDICTION WRIT PETITION (CIVIL) NO. 95 OF 2012

Devika Biswas

....Petitioner

versus

Union of India & Ors.

....Respondents

J U D G M E N T

Madan B. Lokur, J.

1. This public interest petition raises very important issues concerning the entire range of conduct and management, under the auspices of State Governments, of sterilization procedures wherein women and occasionally men are sterilized in camps or in accredited centres. The issues raised also include pre-operation procedures and post-operative care or lack of it. A sterilization surgery does not appear to be complicated and yet several deaths have taken place across the country over the years. Undoubtedly, this needs looking into by the Government of India and the State Governments and remedial and corrective steps need to be taken. Persons who are negligent in the performance of their duties must be held accountable and the victims and their family provided for. It is time that women and men are treated with respect and dignity and not as mere statistics in the sterilization program.
2. The petitioner Devika Biswas is a public spirited individual of Araria district in Bihar. She is

a health rights activist with extensive professional experience in the development and health sectors. She has worked in Uttar Pradesh, Delhi, Jharkhand and Bihar in her capacity as a health rights activist. She has also been associated with the Integrated Child Development Scheme in Bihar and has published articles and books in her field of specialization.

3. Sometime in 2005 the issue of sterilization procedures for females and males under the Population Control and Family Planning program or the Public Health program of the Government of India came up for consideration before this Court in a petition filed by Ramakant Rai. The petition was substantially decided by this Court on 1st March 2005 by passing several directions. The directions are reported as *Ramakant Rai (I) & Anr. v. Union of India & Ors.*¹
4. Pursuant to the directions given by this Court, the Government of India published a Quality Assurance Manual for Sterilization Services (in 2006); Standards for Female and Male Sterilization (in 2006); and Standard Operating Procedures for Sterilization Services in Camps (in 2008). These manuals really form the procedural and substantive basis for conducting sterilization procedures both of females and males in the country under the population control and family planning program or the¹ (2009) 16 SCC 565 public health program.
5. What seems to have provoked Devika Biswas in filing a writ petition under Article 32 of the Constitution in this Court is that on 7th January 2012 as many as 53 women underwent a sterilization procedure in a camp in highly unsanitary conditions in Kaparfora Government Middle School, Kursakanta, Araria district in Bihar between 8 p.m. and 10 p.m. through a single surgeon. In fact, some of the broad issues concerning the sterilization camp held on 7th January 2012 as found on investigation by Devika Biswas, included an absence of pre-operative tests on the women or proposed patients; they were not given any counseling of any kind at all; they had no idea about the potential dangers and outcomes of the sterilization procedure; the sterilization procedures were carried out in a school and not in a government hospital or a private accredited hospital; running water was not available at the site; the sterilization procedures were carried out under torch light with the women being placed on a school desk; the surgeon did not have any gloves or at least did not change the gloves available with him; no emergency arrangements were made etc. etc. Essentially, the entire camp was conducted in unsanitary conditions, in an unprofessional and unethical manner. What is worse is that the camp was conducted under the auspices of an NGO called Jai Ambey Welfare Society who had been granted accreditation by the District Health Society only a few months earlier that is on 29th November, 2011 apparently without following any formal and transparent procedure.
6. As a result of the sterilization camp, many women who were operated upon underwent tremendous physical pain and anguish and were traumatized. Consequently, a series of complaints were filed and they were registered at Kursakanta Police Station on 8th January 2012 being S.DE No.135/12, 136/12, 137/12 and 144/12. Some of these complaints were inquired into by the State authorities and it was found that the sterilization camp was a success

¹ (2009) 16 SCC 565

except that an expired medicine had been given to the women. On the other hand, the study and the investigations carried out by Devika Biswas along with a journalist called Francis Elliott concluded that the sterilization camp did not meet any of the requirements laid down by this Court or by the Government of India and that this was confirmed by the women who were operated upon as well as their relatives.

7. Devika Biswas then felt compelled to file a public interest litigation in this Court to ensure that sterilization procedures nationwide are conducted in accordance with accepted legal norms, medical procedures and the provisions of the manuals and that those women and men who suffer due to the failure or complications in implementing the norms, procedures and provisions are given adequate compensation. That is really the core issue raised by Devika Biswas and that such instances are not repeated.
8. In this context, Devika Biswas says in her writ petition that on 9th February 2008 the State Health Society in Bihar issued a memorandum to the Civil Surgeon in each district in the State. The result of this memorandum was that sterilization procedures could now be conducted in accredited private health facilities also in a camp mode. The memorandum also mentioned that the State Government would provide funds to the private facilities and the motivators as per the Government of India norms for conducting sterilization procedures. However it was made clear that extra funds for camp management, transportation etc. would not be provided by the Government to the accredited private facilities.
9. This was followed by another memorandum dated 9th February 2009 regarding sterilization procedures carried out at government institutions by empanelled private doctors. The memorandum issued by the State Health Society of Bihar to the Civil Surgeon in all districts stated that an empanelled private doctor might also be permitted to carry out family planning sterilization procedures in government institutions. The Quality Assurance Committee of the district was entitled to employ private doctors including contractual doctors whose term had expired for carrying out the sterilization procedures.
10. The petition filed by Devika Biswas goes on to say that in 2010 a Non Government Organization (NGO) called the Centre for Health and Social Justice released a report concerning the quality of care and consequences of female sterilization procedures in Bundi district of Rajasthan in 2009-10. According to the report 749 women (mainly underprivileged) were sterilized at Public Health Centres, Community Health Centres or Camps. They were interviewed by researchers who found that a significant number of them were not counseled about the permanent nature of the sterilization procedure and almost 88% of them told the researchers that they did not receive any information about potential complications, failures or side effects of the sterilization procedure. The report indicated that while the internationally accepted failure rate is 0.5% the failure rate in Bundi district in Rajasthan was 2.5% that is 5 times the acceptable international standard.
11. Similarly, in February 2012 a Fact Finding Mission by a social activist reported that sterilization

procedures carried out in three districts in Maharashtra, that is, Nagpur, Chandrapur and Gadchiroli found that sterilization camps were routinely conducted in unsanitary and unsafe facilities.

12. Again in February 2012 a sterilization camp in Madhya Pradesh was conducted in Balaghat district without following any of the established procedures and tribals were lured into sterilization camps by motivators who collected a substantially large amount over and above the financial norms fixed by the Government of India.
13. In Kerala also a similar story was repeated in July 2011 highlighting that sterilization procedures were not conducted in accordance with the prescribed requirements of law or the procedures laid down by the Government of India. In paragraph 40 of the writ petition, Devika Biswas submits that “In July 2011, a local journalist in Wayanad and the Chief of the Kattunayakan tribe, who serves as the President of the Primitive Tribal Association, met with health workers in Kerala. They shared stories of men and women who were told by the government health workers that it was compulsory to undergo sterilization. The Chief is concerned about government coercion and compulsion in sterilization and its effect on the tribe’s population.”
14. In this background, Devika Biswas prayed for a series of directions including setting up a committee to investigate the facts relating to the sterilization camp held on 7th January 2012 and to initiate departmental and criminal proceedings against those who were involved in the sterilization camp. It is also prayed that the guidelines given in the manuals prepared by the Government of India should be scrupulously adhered to so that such incidents do not recur in any part of the country and if they do, additional compensation should be paid to the women in distress.
15. In this writ petition, we are primarily concerned with the affidavits of the Union of India, the States of Bihar, Kerala, Madhya Pradesh, Maharashtra and Rajasthan since allegations have been made in respect of sterilization camps held in these States only. However, during the course of hearing of this writ petition, allegations surfaced with regard to sterilization camps conducted in Bilaspur district, Chhattisgarh [between 8th and 10th November 2014] and so we are also concerned with the allegations made in respect of the camps conducted in that State as well.
16. What was brought to our notice with regard to the sterilization camps conducted in Bilaspur district was that as many as 137 women were subjected to a sterilization procedure and unfortunately 13 of them died. Many others complained of problems such as vomiting, difficulty in breathing, severe pain etc. They were taken to nearby hospitals and discharged after necessary treatment. It appeared that some women who had not undergone a sterilization procedure also had similar complaints and some of them died thereby increasing the number of deaths to over 13. Undoubtedly, this was a matter of great concern brought to our notice during the pendency of the writ petition.

Orders passed by this Court

17. Notice in the writ petition was issued on 2nd April 2012 and thereafter the petition was taken up for active consideration only on 30th January 2015 when the Social Justice Bench of this Court was seized of this matter and after completion of pleadings and instructions received by the learned Additional Solicitor General from the Union of India.
18. On 30th January 2015 after hearing learned counsel, a request was made by us to the learned Solicitor General to ensure that a chart be prepared giving the status of implementation of each direction given in *Ramakant Rai (I)*. Details with regard to the implementation of the Family Planning Indemnity Scheme, 2013 were also sought particularly with regard to the release and utilization of funds under the said Scheme.
19. During the hearing, the events in Bilaspur, Chhattisgarh (mentioned above) also came up for consideration and so the State of Chhattisgarh was required to file an affidavit stating the steps taken to ameliorate the conditions of the persons who had faced the recent tragedy. The State Government was also required to indicate the action taken against the doctors involved and steps taken to educate the people in Chhattisgarh with regard to the sterilization procedure and its impact.
20. The petition was then taken up for consideration on 20th March 2015 when it was noted that even though Chhattisgarh had filed an affidavit dated 19th February 2015, it had not given sufficient particulars and details with regard to the action taken subsequent to the mishap in the sterilization camp. Chhattisgarh was therefore required to file a proper and detailed affidavit including a copy of a sample FIR, post mortem report and charge sheet filed, if any.
21. With regard to an affidavit filed by the Union of India in relation to the implementation of the Family Planning Indemnity Scheme, 2013 it was noted that the manner of utilization of funds was not indicated. The learned Solicitor General assured this Court that full details in this regard would be furnished and also an audit would be conducted to ensure that the funds are utilized for the purpose for which they have been given by the Government of India to the State Governments. Unfortunately, these details have not yet been furnished and we have only the figures giving the budget approved as well as the expenditure incurred by the State Governments and Union Territories.
22. On 17th April 2015 the writ petition was again taken up for consideration and as an interim measure the Secretary in the Ministry of Health and Family Welfare of the Government of India was directed to hold a meeting with his counterparts in the States and the Union Territories to arrive at a consensus on the effective implementation of the various schemes relating to sterilization [of females and males], the Family Planning Indemnity Scheme, 2013 and the directions given in *Ramakant Rai (I)*.
23. Chhattisgarh was also required to file a Status Report on the progress made by a Commission set up by it (the Ms. Anita Jha Commission) to look into the tragedy that had occurred in the sterilization camps held in Bilaspur.
24. The learned Advocate General appearing for the State of Chhattisgarh stated that he would

look into the issue of taking action against the manufacturer of the drug used in the sterilization camps and the feasibility of filing a charge sheet against the offenders and to step up efforts to arrest the absconding persons or if necessary to declare them proclaimed offenders.

25. In the hearing on 14th August 2015 it was noted that the Secretary in the Ministry of Health and Family Welfare had held a meeting, as earlier directed, on 15th May 2015. It was noted that one of the suggestions given in that meeting was that similar high level meetings should be conducted every six months. Accordingly, we expected the Secretary in the Ministry of Health and Family Welfare to conduct a similar meeting after six months that is on or about 15th November 2015.
26. As far as Chhattisgarh is concerned, it was noted that it had filed an affidavit and the learned Advocate General stated that the Ms. Anita Jha Commission submitted its report on 10th August 2015 and that the report was likely to be considered by the State Cabinet in the next couple of weeks.
27. The learned Advocate General informed us that two charge sheets had been filed in connection with the tragedy and that no FIR was pending investigation. He further stated that some scientific reports were expected from a Forensic Science Laboratory and a supplementary charge sheet would be filed, if necessary, immediately thereafter.
28. With regard to two absconding persons concerned with the tragedy, it was stated by the learned Advocate General that they had been declared proclaimed offenders and a reward had also been announced for their whereabouts.
29. In the hearing on 4th December 2015 we were informed that the report given by Ms. Anita Jha had since been accepted by the State Cabinet. Subsequently, on 29th March 2016 we were informed that an Action Taken Report on the Ms. Anita Jha Commission Report had been placed before the Legislative Assembly.
30. Since the proceedings in this case were not adversarial in nature we requested the learned Additional Solicitor General appearing in the matter as well as the learned Senior Counsel to sit down and give suggestions on how to implement the Standard Operating Procedures and the Guidelines laid down by the Union of India in the matter of sterilization procedures.
31. On 4th August 2016 when we heard the writ petition, we were informed that a meeting was in fact held between the learned Additional Solicitor General, learned Senior Counsel for Devika Biswas and officials of the Ministry of Health and Family Welfare of the Government of India and that an affidavit in this regard had also been filed. We then heard learned counsel for the parties and reserved judgment.

Affidavits filed by the Union of India

32. The Ministry of Health and Family Welfare of the Government of India has filed as many as 10 (ten) affidavits. It is not necessary to traverse each of them in detail. However, it is necessary to highlight the broad submissions made. These are:

- (i) It is admitted that the Union of India received a complaint with regard to the sterilization camp held on 7th January 2012 and a report had been called for in this regard. A report has since been received from the concerned authorities in the State of Bihar and Dr. Abhay Kumar Chowdhary, a contract physician at the Primary Health Centre had since been dismissed and it had further been ordered that he may not be employed in any government work in future. First Information Reports (FIRs) were lodged in respect of the events of 7th January 2012, investigations have concluded and charge-sheets filed.
- (ii) The Government of India has published several Manuals for the guidance of the State Governments and Union Territories in respect of sterilization procedures and conducting such camps. These are:
 - (a) Standards for Female and Male Sterilization, 2006;
 - (b) Quality Assurance Manual for Sterilization Services, 2006;
 - (c) Standard Operating Procedures for Sterilization Services in Camps, 2008;
 - (d) Fixed Day Static Approach for Sterilization Services, 2008;
 - (e) Family Planning Insurance Scheme;
 - (f) Compensation Scheme for Acceptors of Sterilization (revised on 31st October 2006 and improved with effect from 7th September 2007);
 - (g) Standards and Quality assurance in Sterilization Services, 2014 including Standard Operating Procedure for camps;
 - (h) Reference manual for Female Sterilization, 2014;
 - (i) Reference Manual for Male Sterilization, 2013;
 - (j) Manual for Family Planning Indemnity Scheme, 2013 (updated in 2016) ;
 - (k) Frequently Asked Questions, 2016.
- (iii) Public Health is a State subject occurring in Entry 6 of List II of the Seventh Schedule of the Constitution. The Government of India only plays a supportive and facilitative role in achieving health welfare schemes and it is essentially the State Government that is in the best position to monitor the quality of services in accordance with agreed benchmarks.
- (v) The following funds have been approved and utilized (in lakhs) by the States under the Family Planning Indemnity Scheme, 2013:

Approval 2013-14	Expenditure 2013-14	Approval 2014-15	Expenditure 2014-15 (till end of 3 rd quarter)
1566.69	675.59	1485.80	828.19

At this stage it may be mentioned that the coverage under the Family Planning Indemnity Scheme is as follows:

Section	Coverage	Limits
1.	Death following sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital	Rs. 2 lakh
2.	Death following sterilization within 8-30 days from the date of discharge from the hospital	Rs. 50,000/-
3.	Failure of sterilization	Rs. 30,000/-
4.	Cost of treatment in the hospital and upto 60 days arising out of complication following sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge	Actual not exceeding Rs. 25,000/-
5.	Indemnity per doctor/health facilities but not more than 4 in a year	Up to Rs. 2 lakh per claim

The Union of India has given no clear-cut answer regarding audit of disbursement of the amounts, except to say that the States and the Union Territories are required to follow the financial management system and are required to submit statutory audit reports, utilization certificates, quarterly summary on concurrent audits etc. Whether this is being adhered to by the States and the Union Territories is not mentioned. It is also not clear whether the accounts of the various organizations involved in sterilization procedures are in fact open for inspection by the sanctioning authority and audit including the Comptroller and Auditor General of India and the internal audit of the Ministry of Health and Family Welfare of the Government of India.

- (iv) The Union of India has issued an advisory to all the States and Union Territories on 30th December 2014 to adhere to the standard operating procedures at all levels to prevent and pre-empt incidents that might adversely affect the health of clients due to sterilization procedures.

- (v) In the high level meeting held on 15th May 2015 (pursuant to orders passed by this Court) the following key action points were agreed upon:
- (a) Sterilization services must be provided in a client friendly manner in a conducive environment after taking informed consent. Safety of those who opt for it should be ensured.
 - (b) A mechanism be put in place wherein service providers or managers are not victimized or arrested without instituting a proper enquiry by the district/State quality assurance committees.
 - (c) All States to conduct workshops on quality in sterilization services orienting its programme managers and service providers both at the State and district level on the updated manuals on standards, male and female sterilization and family planning indemnity scheme.
 - (d) All Government of India guidelines to be strictly adhered by the States.
 - (e) A periodic assessment of all the facilities and fixed day camps by 1-2 members of the sub-committees under the SQAC/DQACs [State Quality Assurance Committee/District Quality Assurance Committee] on implementation of the infection prevention protocols as well as the efficacy of the services provided, should be carried out (as laid down in the Manuals).
 - (f) The issue of shortage of pool of providers for sterilization could be addressed by resorting to compulsory training of MBBS medical officers when they join government service.
 - (g) Onsite Training/mentoring be initiated by identifying high caseload facilities (first) to undertake sterilization trainings. This will ensure the service provider is available at the facility to undertake their primary task of providing services to the clients in addition to provide training to prospective trainees.
 - (h) Retraining of providers who are either short on confidence or have high failure rates.
 - (i) There should be more thrust on Minilap Sterilization as it leads to fewer failures and complications.
 - (j) The scope of increasing the basket of contraceptive choices like injectables/implants and weekly pills like 'Saheli' be explored urgently to provide more choice.
 - (k) The idea of mobile teams or clinical outreach teams needs to be encouraged to address the issue of shortage of surgeons.

- (l) Every case of sterilization death must be audited as per format laid down and reported to the Government of India.
 - (m) Line listing of deaths and failures to be undertaken district/facility wise and surgeon wise. Disbursal of claims for deaths, failures and complications should be computerized.
 - (n) To address the issue of sterilization failures, sterilization certificates should be issued after at least one month in case of female sterilization and after three months in case of male sterilization.
 - (o) States to take urgent steps to rejuvenate the Family Planning Programme with the ultimate aim of reducing the maternal and infant mortality and morbidity in addition to achieving population stabilization.
 - (p) Government of India to conduct high level meeting like the instant one with all States to acquaint them with the latest policies and programmes of the Government of India on a yearly basis.
- (vi) In the high level meeting held on 17th November 2015 (pursuant to orders passed by this Court) the following key priority areas were shared with the State Governments and Union Territories:
- (a) Uniform consent forms should be available in all facilities which should be duly filled in and the consent of the client should be taken prior to the procedure in all cases.
 - (b) State Quality Assurance Committee (SQAC)/District Quality Assurance Committee (DQAC) and State Indemnity Sub Committee (SISC)/District Indemnity Sub Committee (DISC) to be constituted as per the GOI guidelines.
 - (c) All the Family Planning guidelines should be printed and disseminated at the State/district as well as facility level.
 - (d) State/District level orientation of all the program managers and providers for the guidelines and protocols to be completed in all States.
 - (e) Members of SQAC and DQAC should conduct periodic supportive supervision visits as per quality protocols. The findings of the same are to be documented and corrective actions should be taken.
 - (f) Training calendar for training newly recruited doctors is to be prepared and updated in each State.
 - (g) Line listing of all the sterilization providers needs to be prepared and periodically updated by all States.
 - (h) Every death attributable to sterilization should be audited.
 - (i) Sterilization certificates should be issued as per existing guidelines.

The aforesaid meeting was held through video-conferencing. The representative of Uttar Pradesh could not attend due to a State holiday and since the office of the National Informatics Centre in the State was closed. It may be mentioned that this is somewhat odd and suggests that responsible officers in the State of Uttar Pradesh seem to give more importance to State holidays rather than issues relating to Family Planning. This is most unfortunate, to say the least.

- (vii) A National Summit on Family Planning was held on 5th and 6th April 2016. As a result of several workshops and summits held from time to time on issues relating to family planning and the directions given by the Court from time to time the following practical and pragmatic measures were proposed by the Government in addition to the new guidelines proposed to be undertaken:
 - (a) Conducting annual review workshops of the programme in all States of India with the State and district programme managers and service providers.
 - (b) Monthly monitoring of at least 2 public health facilities and 1 accredited private/NGO facility by SQAC/DQAC.
 - (c) Replacement of operational 'Camps' by regular 'Fixed day services' over the next three years.
 - (d) Further Strengthening of the State Quality Assurance Committee (SQAC) and District Quality Assurance Committee (DQAC) mechanism.
 - (e) Close monitoring, reviewing and collection of reports of deaths attributable to sterilization by the Government of India.
 - (f) Conducting Client exit interviews of 10% cases as per the prepared checklist.
 - (g) Feedback from beneficiaries by Maternal and Child Health Tracking Facilitation Centre (MCTFC).
- (viii) Our country has adopted a comprehensive RMNCH+A (Reproductive, Maternal, Neonatal, Child and Adolescent Health) strategy under which the Family Planning program is being emphasized to promote reproductive health and reduce maternal, infant and child mortality and morbidity.
- (ix) The States of Tamil Nadu, Maharashtra, Sikkim and Goa have already phased out the holding of sterilization camps. During the course of submissions we were informed by the learned Advocate General for Chhattisgarh that that State has also phased out such camps. As far as the Union of India is concerned, it proposes to ensure the phasing out of such camps over the next three years.
- (x) Several improvements have been made in the Family Planning program and sterilization procedures. They are:
 - (a) Decline in deaths following sterilisation from 140 in 2014-15 to 89 in 2015-16 (as per data available on the web based HMIS till 31.3.2016);

- (b) Decline in the number of failures from 5928 in 2014-15 to 2093 in 2015-16 (as per data available on the web based HMIS till 31.3.2016);
- (c) The empanelled list of providers is available in every district;
- (d) Surgeons are not performing more than 30 cases per day;
- (e) Camps are being held only in public health facilities or accredited private/ NGO facilities.
- (f) Workshops relating to Family Planning programme have been held in 28 out of 29 States (as on 21st July, 2016). Unfortunately, no such workshops were held after 24th August, 2015.
- (g) The number of deaths attributable to sterilisation procedures in 2014-2015 was 140 but it has come down in 2015-2016 to 113.
- (h) In 2015-2016 clients exit interviews have been conducted in respect of 1,06,055 persons.
- (i) Monitoring and supervision of facilities by SQAC/DQAC in 2015-2016 in regard to public facilities is as high as 12,044 and with regard to private accredited facilities it is as high as 2,984.
- (j) The amount allotted for quality improvement which includes training, family planning equipments, other service delivery activities, human resource cost, infrastructure share, planning and monitoring (including quality assurance) and family planning commodities is as follows:

Year	2013-14	2014-15	2015-16
Amount in Crores	1000.7	1648.07	1243.9

The sum and substance of the affidavits is that it is not as if the Ministry of Health and Family Welfare of the Government of India is sitting idle and not taking adequate interest in the success of the Family Planning program and particularly in sterilization procedures in public and private health facilities. While deficiencies and faults have been pointed out, there has also been considerable improvement in an ongoing exercise of national importance.

Affidavits filed by the State of Bihar

- 33. The State of Bihar has filed two affidavits, a Status Report and Written Submissions.
- 34. The broad allegations made by Devika Biswas have been accepted and it is accepted that a sterilization camp was conducted by Jai Ambey Welfare Society (NGO) late in the evening of 7th January 2012 in violation of the orders of the concerned Civil Surgeon. An FIR has been lodged against the NGO not only for violating the directives but also for distributing expired medicine to the beneficiaries of the family planning camp.

35. It is further stated that the NGO has since been blacklisted and steps have been taken for giving compensation to some of the women who had developed complications during the surgeries.
36. The blacklisting is confirmed by respondent No. 4, that is, Kumar Nath Choudhary, Secretary of Jai Ambey Welfare Society who filed an affidavit on 14th January 2013 in which it is stated that hue and cry was made about the sterilization camp by anti-social elements and as a result three FIRs, namely, Kursakanta P.S. Case No.03/2012, Case No.05/2012 and Case No.14/2012 have been lodged against the NGO.
37. Two charge-sheets have been filed in respect of Kursakanta P.S. Case No.03/2012 and Case No.05/2012.
38. As regards Kursakanta P.S. Case No.03/2012, Charge Sheet bearing No. 23 of 2012 dated 09.03.2012 and supplementary Charge Sheet No. 167 of 2012 dated 31.12.2012 have been submitted. Cognizance of the offence has been taken and thereafter Revision Application No. 44/369/12 has apparently been filed by the accused persons and that is pending in the District Court in Araria.
39. As regards Kursakanta P.S. Case No.05/2012, Charge Sheet No. 24 of 2012 dated 12.03.2012 and supplementary Charge Sheet No. 87 of 2013 have been submitted. Cognizance of the offence has been taken on 28.06.2012 and a Revision Petition has apparently been filed by the accused bearing No. 31/226/13 which is pending in the District Court in Araria.
40. As regards Kursakanta P.S. Case No.14/2012 is concerned, the details are not available on record.
41. We have also been told that an FIR has been filed against the NGO Jay Ambey Welfare Society for distributing expired medicines to the beneficiaries of the Family Planning camp held on 7th January 2012. A Charge Sheet has been filed in this regard and cognizance of this offence has also been taken by the Trial Court, but again the details are not available.
42. It is also admitted by the State of Bihar that inquiries into the events that took place on 7th January 2012 have been concluded and show cause notices have been issued to the Medical Officer in charge in the Primary Health Centre in Bausa, Purnia as well as Kursakanta, Araria and also to the Civil Surgeon, Purnia.
43. That the situation in Bihar has not improved is clear from the fact that in Saran district the accreditation of Gunjan Maternity and Surgical Clinic at Chhapra to conduct sterilization procedures was cancelled on 4th March 2012, just a few months after the incident in Araria district. Affidavit filed by the State of Kerala
44. The State of Kerala has filed a Statement of Facts through a letter dated 15th March 2013. The Statement of Facts is not accompanied by an affidavit and the first page of the Statement of Facts is not on the record of this case. However, the letter states, *inter alia*, that "In Kerala sterilization camps are conducted only in well equipped centres (usually in first referral units and above hospitals) where there are operation theatre facility, lab facility, referral facility are in place." It is also stated that "sterilization procedures are carried out in hygienic, well equipped

hospitals under the control and supervision of qualified empanelled doctors.” This is reiterated in an affidavit dated 1st July 2013 filed by the State of Kerala.

45. In response to the submission made in the writ petition, the State of Kerala states in paragraph 11 of its affidavit:

“[The] tribal population of Kerala State is accorded special consideration for its dealing members. There is no compulsion of promotion of sterilization as part of Government policy. At the same time family planning services are not denied to this segment of the population if demanded. Felt need of the community is assessed by the Health Worker and various options are put before them explaining the merits and demerits of each method and encouraging to make right choice.”

There is therefore no specific denial of the submission made by Devika Biswas in her writ petition.

Affidavit filed by the State of Madhya Pradesh

46. The State of Madhya Pradesh has filed only one affidavit dated 7th August 2013 and the allegations made by Devika Biswas have not been denied in that affidavit.
47. However, the State of Madhya Pradesh denies coercive sterilizations and asserts that sterilization is undertaken only after informed consent of the patient. The State further submits:

“The State Government has issued instructions for taking due precautions for sterilization operations. The State Government has formed Quality Assurance Committee in each District of the State which is headed by the Chief Medical and Health Officer of the district. The function of the Quality Assurance Committee is to review all types of cases where there is some complication and take necessary steps to rectify the same.”

There is no specific denial of the events in Balaghat district.

Affidavit filed by the State of Maharashtra

48. The State of Maharashtra has filed only one affidavit dated 14th August 2012 in which it is generally stated that the family planning program is being conducted satisfactorily and a large number of statistics have been given in support of this submission. However, with regard to the sterilization camp held in Nagpur, Chandrapur and Gadchiroli districts it is stated as follows:

“It is respectfully submitted that in the light of facts submitted in the Petition by the Petitioner, detailed report has been called from the Civil Surgeon, Gadchiroli, Chandrapur and Nagpur District which is marked and annexed as Annexure-1. However, keeping in view the gravity of such instances reported, State has taken immediate corrective action and instructions have already been issued to all the District Health Officers and Civil Surgeons to perform the family planning operations as per the standards prescribed by Govt. of India in hygienic conditions.”

No detailed report has been annexed and no further affidavit was filed by the State of Maharashtra

regarding any action taken against any officer responsible for the mishap, any compensation paid or any further action taken in this regard.

Affidavit filed by the State of Rajasthan

49. The State of Rajasthan in its affidavit filed on 23rd November 2012 does not specifically contradict the contents of the report relating to the sterilization procedures carried out in Bundi district but only affirms that the standard operating procedures are being followed and that the failure rate is in conformity with the failure rate prescribed by the Government of India.
50. The State of Rajasthan maintains that the proposed patients are sufficiently instructed and advised with respect to both the sterilization itself as well as post-sterilization care. The State further mentions that continuous efforts are made by the health employees “to motivate females to take up sterilization surgery”. The failure rate at Bundi district “is in conformity to the failure rate prescribed by the Government of India”. The State submits that sufficient steps have been taken for implementation of the directions in *Ramakant Rai (I)* as well as the guidelines of the Government of India.

Affidavits filed by the State of Chhattisgarh

51. The State of Chhattisgarh has taken up the issue of mismanagement of the sterilization camps in Bilaspur district with due promptitude and seriousness and has filed detailed affidavits that not only specify the ameliorative steps taken but also the preventive steps against recurrence of a similar tragedy.
52. Chhattisgarh has confirmed that sterilization camps were organized in Sakri village of Bilaspur district on 8th November 2014 and in Gorela, Pendra and Marwahi in Bilaspur district on 10th November 2014. In all 137 operations were conducted and many of those operated upon complained of vomiting, pain and difficulty in breathing. Consequently, all of them were admitted in nearby hospitals for treatment. Unfortunately, 13 deaths took place despite relief measures including bringing in a team of doctors from the All India Institute of Medical Sciences in New Delhi.
53. Apart from these 137 persons, 37 persons who were not operated upon also had similar complaints and 5 (five) of them died thereby bringing the total number of deaths to 18. It appears that the cause of death of these 5 (five) persons was not related to the sterilization procedure but was due to consumption of Ciprocin 500 tablet.
54. By way of monetary compensation, the State Government has given Rs. 4 lakhs to the families of those who died and Rs. 50,000/- to those who were discharged from medical institutions. The children of the deceased have been adopted by the State Government which has taken the responsibility of providing them free education and health care till they are 18 years of age. The State Government has also put in an amount of Rs. 3 lakh in a fixed deposit for children of the persons who died in the tragedy. The children would be entitled to the amount on attaining the age of 18 years.

55. Departmental action has been taken against the doctors involved in the sterilization camps. Two of them have been dismissed from service while two others have been suspended pending a departmental enquiry. The Licensing Authority has also been suspended.
56. A Judicial Commission of Inquiry headed by a retired District Judge Ms. Anita Jha was set up to give its findings on the criminal culpability and accountability of the persons concerned. The report given by the Ms. Anita Jha Commission has been accepted by the State Government and also acted upon.
57. Criminal proceedings in the form of Charge Sheet No.19/2015 dated 15th February 2015 has been filed in the Court of Judicial Magistrate, First Class at Bilaspur against Dr. R.K. Gupta, Ramesh Mahawar, Sumit Mahawar (manufacturers of Ciprocin 500 tablets), Rajesh Khare, Rakesh Khare and Manish Khare (suppliers of Ciprocin 500 tablets). Rakesh Khare and Manish Khare have since been declared proclaimed offenders and their property attached and a reward for their arrest and information of their whereabouts has also been announced.
58. As regards measures taken to prevent the recurrence of such an incident, Chhattisgarh has begun placing greater emphasis on spacing measures which will be more effective in population control. Greater emphasis is being placed on vasectomy for gender equity. An advisory has been issued that Ciprocin 500 should not be consumed and efforts are being made to educate people about the importance, benefits, methods and availability of services in health facilities. A mass awareness campaign has also been launched and several other proactive measures have been taken.
59. All in all, the State of Chhattisgarh has reacted positively to the tragedy and has not sought to hide inconvenient facts under the carpet. Further submissions of Devika Biswas
60. Devika Biswas has pointed out in various affidavits filed during the pendency of this writ petition that the campaign for sterilization is effectively a relentless campaign for female sterilization. The web portal of the Ministry of Health and Family Welfare of the Government of India provides statistics on the number of sterilization procedures conducted in the country for 2012-13. The portal indicates that 97.4% of all sterilization procedures during this period were of women.² Devika Biswas alleges that the entire family planning program of Chhattisgarh focuses on female sterilization and the National Health Mission Project Implementation Plan sets targets for female sterilization and allocates 85% of the family planning budget exclusively to female sterilization.
61. More or less confirming the allegations made by Devika Biswas, the affidavits filed by Madhya Pradesh, erstwhile Andhra Pradesh and Goa reflect the fact that the over-whelming number of sterilization procedures is targeted towards women and there is virtually no attention paid to male sterilization.

2. This has now gone up to 98.1% for 2014-15

62. Devika Biswas has also pointed out that data released by the Ministry of Health and Family Welfare during the period 2010-13 shows that at least 363 people have died as a result of sterilization procedures, a very large number of such procedures have failed and that there have been severe complications in respect of several persons who underwent a sterilization procedure. This has resulted in payment of compensation of at least Rs. 50 crores.³
63. The principal problem pointed out by Devika Biswas is with regard to the implementation of the various processes and guidelines issued by the Government of India from time to time. Mere issuance of guidelines by the Government of India does not guarantee their implementation. It is pointed out (for example) that the list of empanelled doctors is not readily available; consent forms are not available in the local language except in the Union Territory of Puducherry; unrealistic targets have been set for sterilization procedures with the result that non-consensual and forced sterilizations are taking place, including of persons who are physically or mentally challenged. Some young persons have been sterilized to meet targets and by and large illiterate persons are sterilized. Devika Biswas is opposed to setting of targets and says that she has the support of the Government of India in this regard, but unfortunately State Governments and Union Territories are still setting informal targets for sterilization.
64. It is further pointed out that there is inadequate monitoring of sterilization camps and facilities. There is little or no monitoring in most camps and health centres, accountability measures are not in place and the rights of thousands of women who undergo sterilization procedures are violated. It is not enough for the Government of India to show that it is merely playing a supportive and facilitative role since the campaign is a national campaign and if it is not properly implemented, it merely leads to passing the buck with the State Government blaming the Government of India and *vice versa*.
65. The strengthening of the Quality Assurance Committees (QAC) and the District Quality Assurance Committees (DQAC) is crucial to the success of a family planning program of which sterilization procedures is one of the elements. Details of the constitution of QACs and DQACs are not available on the website of the Ministry of Health and Family Welfare. There is also no indication of the steps and decisions taken by them or the minutes of their meetings or reports submitted by them. In other words, vital information is simply not available. Devika Biswas doubts whether these Committees meet on a regular basis although it would be appropriate for them to have at least quarterly meetings if not meetings every six months.
66. According to her, unless these existing institutions function effectively and efficiently or are made to function effectively and efficiently, it is very unlikely that any meaningful progress will

3. This information is in fact not very clear from the data on the website of the Ministry but is available at: <http://pib.nic.in/newsite/PrintRelease.aspx?relid=106949>; Press Information Bureau, Government of India, Ministry of Health and Family Welfare, 18.07.2014.

be made in the family planning program of the Government of India, of which sterilization is an important component.

67. With regard to the Family Planning Indemnity Scheme, it is pointed out that regular reviews are not carried out; the utilization of funds made available under the Scheme are mere figures since the details of disbursements in case of death, failure, complication etc. are simply not available anywhere. There is no indication of the number of claims filed, the number of claims rejected and the reasons for the rejection and the amount provided to each successful claimant. The Scheme requires a death audit to be carried out but that is more or less missing in every instance. It is stated that specialists who are conversant with the Scheme are not available at sterilization camps and health centres to explain the Scheme in detail so that there is no difficulty or complication faced in the event of an unfortunate mishap. It should be the duty of such a specialist to ensure that each person proceeding to undergo a sterilization procedure has a copy of all the required documents so that there is no difficulty faced later on. This will also ensure that each person gives an informed consent to the sterilization procedure in a language that he or she understands. In fact, all information that is disseminated with regard to the sterilization procedure should be made available in the local language at all Government health facilities and accredited private facilities.
68. It is high time, according to Devika Biswas, for the Government of India to look at the quality of care made available to persons post a sterilization procedure. As is clear from various documents on record including the Ms. Anita Jha Commission Report, after-care facilities in terms of counseling, assistance, follow-up etc. are totally absent.

Is it a public health issue?

69. The fundamental error that the Union of India is making (and it has repeated that in its affidavits) is by asserting that the effective implementation of the sterilization program is the concern of each State since it is a "Public health" issue covered by Entry 6 of List II in the Seventh Schedule (the State List) of the Constitution. Apart from the fact that the various entries in the Seventh Schedule relate to legislative power, the error made by the Union of India is in completely overlooking the more appropriate Entry in the Concurrent List that is Entry 20A which is "Population Control and Family Planning". This was inserted by the Constitution (Forty-second) Amendment Act, 1976. If the sterilization program is intended for population control and family planning (which it undoubtedly is) there is no earthly reason why the Union of India should refer to and rely on Entry 6 of the State List and ignore Entry 20A of the Concurrent List. Population control and family planning has been and is a national campaign over the last so many decades. Therefore, the responsibility for the success or failure of the population control and family planning program (of which sterilization procedure is an integral part) must rest squarely on the shoulders of the Union of India. It is for this reason that the Union of India has been taking so much interest in promoting it and has spent huge amounts over the years in encouraging it. It is rather unfortunate that the Union of India is now treating the sterilization program as a Public Health issue and making

it the concern of the State Government. This is simply not permissible and appears to be a case of passing the buck.

70. As regards Entry 20A of the Concurrent List, the Justice Sarkaria Commission had this to say in Chapter II titled Legislative Relations in paragraph 2.21.08:

“Only one State Government has suggested that this Entry should be transferred to the State List. According to them family planning facilities should be an integral part of the health facilities which is a State subject and the present dichotomy between the two facilities hampers their adequate integration. Population control and family planning are a vital part of the national effort at development. This Entry was inserted by the Forty-second Amendment to the Constitution recognising the importance of this matter. It is well known that a significant part of the fruits of development is neutralised by the high growth in population. With more mouths to feed, less savings are available for development. Large addition to the population has its impact on every aspect of the nation’s life. Many of the ills of the society can be traced back to large numbers who are unable to find a rewarding employment. It is necessary to recognise this inter-dependence between family planning and other sectors. We are, therefore, of the view that Population Control and Family Planning is a matter of national importance and of common concern of the Union and the States.”

Notwithstanding the view of that one State Government, the Union of India did not transfer Entry 20A to the State List, thereby making its intentions quite clear and obvious.

71. When the Union of India formulates schemes of national importance such as family planning, their implementation is undoubtedly dependent on the State Governments since they have the requisite mechanism for implementing the schemes and can also take into account the needs that are particular to the State and its people. In this manner, the cooperation of the Union of India and all State Governments is indispensable to the success of such national programs. Adverting to the provisions of the Constitution that allow for such coordination between the Union and States, the Justice Sarkaria Commission held that these provisions are not repugnant to but instead further the principle of federalism.

72. In the same manner, it is imperative for both the Union of India and the State Governments to implement schemes announced by the Union of India in a manner that respects the fundamental rights of the beneficiaries of the scheme. Given the structure of cooperative federalism, the Union of India cannot confine its obligation to mere enactment of a scheme without ensuring its realization and implementation.

73. Apart from anything else, by not giving the sterilization program the importance it deserves (apart from other methods of population control and family planning) and trying to pass the buck to the State Governments, the Union of India is attempting to find an excuse for failure in its duty of effectively monitoring a program of national importance. This game of passing the parcel and treating a national program as a public health issue has to stop and somebody

must take ownership of the Population Control and Family Planning program. Draft National Health Policy.

74. To compound the problem, and it is much more than a pity, our country does not seem to have any health policy. The draft of a National Health Policy, 2015 was put up on the website on the Ministry of Health and Family Welfare of the Government of India in December 2014 for comments, suggestions and feedback but even after more than one and a half years, the website of the said Ministry shows that the National Health Policy has not been finalized.
75. The draft National Health Policy states that its primary aim is to "...inform, clarify, strengthen and prioritize the role of the Government in shaping health system in all its dimensions..." The draft recognizes the correlation between health and development and also recognizes the high inequity in access to health care.
76. With respect to sterilization, it states that sterilization related deaths are a direct consequence of poor health care quality and is a preventable tragedy. It also recognizes that female sterilizations are safest if performed in an operation theatre which is functional throughout the year and by a professional team with support systems which are in constant use. Camp mode for such operations itself becomes a reason for unsatisfactory quality. More monetary and human resource investment is required for the National Rural Health Mission.
77. Increase in the proportion of male sterilization in the total sterilizations from the existing 5% to at least 30% is stated to be another policy imperative under the health policy. Coercive methods are not justified and are not even effective in meeting the goals of population control. Improved access, education and empowerment should be the aim.
78. Under the head of 'Governance' the draft National Health Policy states:

"One of the most important strengths and at the same time challenges of governance in health is the distribution of responsibility and accountability between the Center and the States. Though health is a State subject, the Center has accountability to Parliament for central funding – which is about 36% of all public health expenditure and in some states over 50%. Further it has its obligations under a number of international conventions and treaties that is a party to. Further, disease control and family planning are in the Concurrent list and these could be defined very widely. Finally though State ownership has been used by some states to become domain leaders and march ahead setting the example for others, the Center has a responsibility to correct uneven development and provide more resources where vulnerability is more."

Surely, someone should be concerned that we do not have a national health policy or is it that we do not need a national health policy and ad hoc measures are good enough?

Female versus male sterilization

79. A perusal of the various affidavits on record indicates that the sterilization program is virtually

a relentless campaign for female sterilization. This is more or less confirmed from the figures available on the website of the Ministry of Health and Family Welfare of the Government of India which indicate the following:

YEAR	2013	2014
Female sterilizations	1,57,431	1,49,262
Male sterilizations	8130	5085
Total sterilizations	1,65,561	1,54,347
% Female sterilizations	95.09%	96.7%
%Male sterilizations	4.91%	3.29%

80. The issue of male versus female sterilizations was debated and discussed during the course of the hearings and it was conceded by all the learned counsel that the sterilization program cannot be targeted primarily towards women but must also actively include the sterilization of men as well. It appears to us, without going into the merits and demerits of the incentives given for undergoing the sterilization procedure, the documents on record indicate that the incentive given to males for undergoing a sterilization procedure is less than it is for females and that may perhaps be one of the reasons why the percentage of males being sterilized is so remarkably low as compared to females. This is an area that the Union of India must address itself to, if nothing else then at least for reasons of gender equity.

Right to life

81. The manner in which sterilization procedures have reportedly been carried out endanger two important components of the right to life under Article 21 of the Constitution – the right to health and the reproductive rights of a person.

(i) Right to health

82. It is well established that the right to life under Article 21 of the Constitution includes the right to lead a dignified and meaningful life and the right to health is an integral facet of this right. In *C.E.S.C. Limited and Ors. v. Subhash Chandra Bose and Ors*⁴ dealing with the right to health of workers, it was noted that the right to health must be considered an aspect of social justice informed by not only Article 21 of the Constitution, but also the Directive Principles of State Policy and international covenants to which India is a party. Similarly, the bare minimum obligations of the State to ensure the preservation of the right to life and health were enunciated in *Paschim Banga Khet Mazdoor Samity v. State of W.B.*⁵

83. In *Bandhua Mukti Morcha v. Union of India & Others*⁶ this Court underlined the obligation of

4. (1992)1SCC 441

5. (1996) 4 SCC 37.

6. (1984) 3 SCC 161.

the State to ensure that the fundamental rights of weaker sections of society are not exploited owing to their position in society.

84. That the right to health is an integral part of the right to life does not need any repetition.

(ii) Right to reproductive health

85. Over time, there has been recognition of the need to respect and protect the reproductive rights and reproductive health of a person. Reproductive health has been defined as “the capability to reproduce and the freedom to make informed, free and responsible decisions. It also includes access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free and responsible decisions about their reproductive behaviour.”⁷ The Committee on Economic, Social and Cultural Rights in *General Comment no. 22 on the Right to Sexual and Reproductive Health* under Article 12 of the International Covenant on Economic, Social and Cultural Rights⁸ observed that “The right to sexual and reproductive health is an integral part of the right of everyone to the highest attainable physical and mental health.”⁹
86. This Court recognized reproductive rights as an aspect of personal liberty under Article 21 of the Constitution in *Suchita Srivastava v. Chandigarh Administration*.¹⁰ The freedom to exercise these reproductive rights would include the right to make a choice regarding sterilization on the basis of informed consent and free from any form of coercion. The issue of informed consent in respect of sterilization programs was considered by the Committee on the Elimination of Discrimination Against Women in *A.S. v. Hungary*¹¹, where the Committee found Hungary to have violated Articles 10(h), 12 and 16, paragraph 1(e) of the Convention on the Elimination of Discrimination Against Women¹² by performing a sterilization operation on A.S. while she was brought in for a caesarean by making her sign a consent form that she did not fully understand. The Committee found that it was not plausible to hold that, in the brief period of 17 minutes commencing from her admission in the hospital to the completion of the surgical procedures, that the hospital personnel provided her with sufficient counselling

7. WHO, *Sexual Health, Human Rights and the Law* (2015) cited from Committee on Economic, Social and Cultural Rights, General comment No. 22 (2016) on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), May 2, 2016, E/C.12/GC/22 at paragraph 6, available at <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/089/32/PDF/G1608932.pdf?OpenElement>

8. India ratified this Convention on April 10, 1979.

9. General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22, available at <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/089/32/PDF/G1608932.pdf?OpenElement>

10. (2009) 9 SCC 1.

11. Ms. A. S. v. Hungary, CEDAW/C/36/D/4/2004, UN Communication No. 4/2004, Committee on the Elimination of Discrimination against Women, Thirty-sixth session, 7-25 August 2006, available at [http://www.un.org/womenwatch/daw/cedaw/protocol/decisions-views/Decision %204-2004%20-%20English.pdf](http://www.un.org/womenwatch/daw/cedaw/protocol/decisions-views/Decision%204-2004%20-%20English.pdf)

and information about sterilization, as well as alternatives, risks and benefits, to ensure that she could make a well-considered and voluntary decision to be sterilized. The Committee held:

“Compulsory sterilization ... adversely affects women’s physical and mental health, and infringes the right of women to decide on the number and spacing of their children.” The sterilization surgery was performed on the author without her full and informed consent and must be considered to have permanently deprived her of her natural reproductive capacity.”

87. It is necessary to re-consider the impact that policies such as the setting of informal targets and provision of incentives by the Government can have on the reproductive freedoms of the most vulnerable groups of 12
- Article 10: States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women - (h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.

Article 12: 1. 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 services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, 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.

Article 16: 1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women - (e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights; society whose economic and social conditions leave them with no meaningful choice in the matter and also render them the easiest targets of coercion. The cases of *Paschim Banga Khet Mazdoor Samity* and *Bandhua Mukti Morcha* have emphasized that the State’s obligation in respect of fundamental rights must extend to ensuring that the rights of the weaker sections of the community are not exploited by virtue of their position. Thus, the policies of the Government must not mirror the systemic discrimination prevalent in society but must be aimed at remedying this discrimination and ensuring substantive equality. In this regard, it is necessary that the policies and incentive schemes are made gender neutral and the unnecessary focus on female sterilization is discontinued.

Supplementary directions

88. On the basis of the submissions before us, we have highlighted some key issues that need active consideration. In addition, our attention was repeatedly drawn to the guidelines given by this Court in *Ramakant Rai (I)* and while it is generally the case of the Union of India and all the States that the guidelines are being followed, we find that at least in respect of some of them,

there is still much more that needs to be done for their effective implementation not only in letter but also in spirit. Some fine-tuning is also necessary in view of the passage of time, change in circumstances and the need to use technology to the optimum.

Accordingly, we find it necessary to issue the following supplementary directions:

1. The State-wise, district-wise or region-wise panel of doctors approved for carrying out the sterilization procedure, must be accessible through the website of the Ministry of Health and Family Welfare of the Government of India as well the corresponding Ministry or Department of each State Government and each Union Territory. The list should contain all necessary particulars of each doctor and not merely the name and designation. This exercise should be completed on or before 31st December, 2016 and thereafter the list be updated every quarter that is by 31st March, 30th June, 30th September and 31st December of every year.

2. The contents of the checklist prepared pursuant to the directions given in *Ramakant Rai (I)* should be explained to the proposed patient in a language that he or she understands and the proposed patient should also be explained the impact and consequences of the sterilization procedure. This can be achieved by (a) ensuring that the checklist is in the local language of the State; (b) it should contain a certificate duly signed by the concerned doctor that the proposed patient has been explained the contents of the checklist and has understood its contents as well as the impact and consequences of the sterilization procedure; (c) in addition to the certificate given by the doctor, the checklist must also contain a certificate given by a trained counselor (who may or may not be an ASHA worker) to the same effect as the certificate given by the doctor. This will ensure that the proposed patient has given an informed consent for undergoing the sterilization procedure and not an incentivized consent.

Sufficient breathing time of about an hour or so should be given to a proposed patient so that in the event he or she has a second thought, time is available for a change of mind.

The checklist prepared pursuant to the direction given in *Ramakant Rai (I)* with the aforesaid modifications should be prepared in the local or regional language on or before 31st December, 2016.

3. The Quality Assurance Committee (QAC) as well as the District Quality Assurance Committee (DQAC) has been set up in every State and District in terms of the directions given in *Ramakant Rai (I)*. However, it is only the designation of its members that has been made available. The details and necessary particulars of each member of the QAC and DQAC should be accessible from the website of the Ministry of Health and Family Welfare of the Government of India as well the corresponding Ministry or Department of each State Government and each Union Territory on or before 31st December, 2016 and thereafter updated every quarter.

4. In addition to the six monthly reports required to be published by the QAC containing of the number of persons sterilized as well as the number of deaths or complications arising out of the sterilization procedure, as already directed in *Ramakant Rai (I)*, the QAC must publish an Annual Report (on the website of the Ministry of Health and Family Welfare of the Government of India

as well the corresponding Ministry or Department of each State Government and each Union Territory) containing not only the statistical information as earlier directed, but also non-statistical information in the form of a report card indicating the meetings held, decisions taken, work done and the achievements of the year etc. This will have a significant monitoring and supervisory impact on the sterilization program and will also ensure the active involvement of all the members of the QAC and the DQAC.

The first such Annual Report covering the calendar year 2016 should be published on the websites mentioned above on or before 31st March, 2017.

5. As many as 363 deaths have taken place due to sterilization procedures during 2010-2013. This is a high figure. During this period, more than Rs. 50 crores have been disbursed towards compensation in cases of death. Apart from steps taken by Bihar and Chhattisgarh during the pendency of the writ petition to mitigate the sufferings of the patients, we have not been told of any death audit conducted by any State Government or Union Territory in respect of any patient, nor have we been informed of any steps taken against any doctor or anybody else involved in the sterilization procedure that has resulted in the death of a patient or any failure or any other complication connected with the sterilization procedure. There is a need for transparency coupled with accountability and the death of a patient should not be treated as a one-off aberration. Therefore, it is directed that the Annual Report prepared by the QAC must indicate the details of all inquiries held and remedial steps taken.

6. With regard to the implementation of the Family Planning Indemnity Scheme (FPIS), there does not seem to be any definitive information with regard to the number of claims filed, the claims accepted and in which category (death, failure, complication etc.), claims pending (and since when) and claims rejected and the reasons for rejection. The QAC is directed to include this information in the Annual Report and the Ministry of Health and Family Welfare of the Government of India as well as the State Governments should make this information accessible on the website, including the quantum of compensation paid under each category and to the number of persons.

We have mentioned above that the learned Solicitor General had assured us on 20th March, 2015 that full details of the funds utilized under the FPIS would be furnished but that information has not been given as yet, necessitating the direction that we have passed.

In addition to the direction relating to the FPIS, the Ministry of Health and Family Welfare should conduct an audit to ensure that the funds given by the Government of India have been utilized for the purpose for which they were given for the period from 2013-14 onwards.

7. The quantum of compensation fixed under the Family Planning Indemnity Scheme (FPIS) deserves to be increased substantially and the burden thereof must be equally shared by the Government of India and the State Government. The State of Chhattisgarh has shown the way in this regard and it would be appropriate if others follow the lead. Every death or failure or complication related to the sterilization procedure is a set-back not only to the patient and his or her family but also in the implementation of the national campaign. We decline to fix the quantum

of compensation but would suggest, following the example of the State of Chhattisgarh, that the amount should be doubled and shared equally.

8. The Union of India is directed to persuade the State Governments to halt the system of holding sterilization camps as has been done by at least four States across the country. In any event, the Union of India should adhere to its view that sterilization camps will be stopped within a period of three years. In our opinion, this will necessitate simultaneous strengthening of the Primary Health Care centres across the country both in terms of infrastructure and otherwise so that health care is made available to all persons. The significance of having well equipped Primary Health Centres across the country certainly cannot be over-emphasized. Therefore, we direct the Union of India to pay attention to this as well, since it is absolutely important that all citizens of our country have access to primary health care.

9. The Union of India should make efforts to ensure that sterilization camps are discontinued as early as possible but in any case within the time frame already fixed and adverted to above. The Union of India and the State Governments must simultaneously ensure that Primary Health Centres are strengthened

10. Although the Union of India has stated that no targets have been fixed for the implementation of the sterilization program, it appears that there is an informal system of fixing targets. We leave it to the good sense of the each State Government and Union Territory to ensure that such targets are not fixed so that health workers and others do not compel persons to undergo what would amount to a forced or non-consensual sterilization merely to achieve the target.

11. The decisions taken in the high level meetings held on 15th May 2015 and 17th November 2015 as well as the National Summit on Family Planning held on 5th and 6th April 2016 should be scrupulously implemented by the Ministry of Health and Family Welfare of the Government of India. The said Ministry should also ensure effective implementation of the decisions taken keeping in mind that the sterilization program is a part of a national campaign.

12. The Union of India is directed to ensure strict adherence to the guidelines and standard operating procedures in the various manuals issued by it. The Sterilization program is not only a Public Health issue but a national campaign for Population Control and Family Planning. The Union of India has overarching responsibility for the success of the campaign and it cannot shift the burden of implementation entirely on the State Governments and Union Territories on the ground that it is only a public health issue. As the Justice Sarkaria Commission put it "Population Control and Family Planning is a matter of national importance and of common concern of the Union and the States."

13. We are pained to note the extremely casual manner in which some of the States have responded to this public interest petition. What stands out is the response of the States of Madhya Pradesh, Maharashtra, Rajasthan and Kerala in respect of which States allegations were made concerning mismanagement in at least one sterilization camp. None of these States have given any acceptable response to the allegations and we have no option but to assume that the camps that have been

referred to in the writ petition were mismanaged as alleged by Devika Biswas. However, the matter should not end here. We direct the Registry of this Court to transmit a copy of this judgment to the Registrar General of the High Court in the States of Madhya Pradesh, Maharashtra, Rajasthan and Kerala for being placed before the Chief Justice of the High Court. We request the Chief Justice to initiate a *suo moto* public interest petition to consider the allegations made by Devika Biswas in respect of the sterilization camp(s) held in these States (the allegations not having been specifically denied) and any other similar laxity or unfortunate mishap that might be brought to the notice of the Court and pass appropriate orders thereon. We also direct the Registry of this Court to transmit a copy of this judgment to the Registrar General of the Patna High Court for being placed before the Chief Justice of the High Court. We request the Chief Justice to ensure speedy completion of the investigations and proceedings relating to the mishap on 7th January 2012 in the sterilization camp in Kaporfora Government Middle School, Kursakanta, Araria district as well as the mishap in Chhapra in Saran district that led to cancellation of the accreditation of Gunjan Maternity and Surgical Clinic on 24th March 2012.

14. The State of Chhattisgarh is directed to implement the recommendations given in the Ms. Anita Jha Report at the earliest and with all sincerity.

15. We have already expressed our sadness at the fact that the National Health Policy has not yet been finalized despite the passage of more than one and a half years. We direct the Union of India to take a decision on or before 31st December, 2016 on whether it would like to frame a National Health Policy or not. In case the Union of India thinks it worthwhile to have a National Health Policy, it should take steps to announce it at the earliest and keep issues of gender equity in mind as well.

Conclusion

89. With the above supplementary directions, the writ petition is disposed of. We must record our appreciation for the efforts put in by Devika Biswas in bringing this vital issue to the notice of this Court and to all the learned counsel and concerned officers of the Ministry of Health and Family Welfare of the Government of India in not treating the public interest litigation as an adversarial proceeding but as a collaborative effort to find a remedy to some problems and improve the well being of the citizens of the country.

..... (Madan B. Lokur)

.....
New Delhi;

(Uday Umesh Lalit)

September 14, 2016

Manju Devi v. State of Madhya Pradesh WP NO. 17358/18

WP-17358-2018

The High Court Of Madhya Pradesh

WP-17358-2018

(SMT. MANJU Vs THE STATE OF MADHYA PRADESH)

Gwalior, Dated : 14-09-2018

Shri Amin Khan, learned counsel for the petitioner.

According to learned counsel for the petitioner, scheme dated 29- 05-2018 has been filed which is relevant for present controversy.

Heard on admission.

Issue notice to the respondents on payment of process fee within seven days by RAD as well as ordinary mode. Notice be made returnable within four weeks.

(ANAND PATHAK) JUDGE

Anil*

Digitally signed by ANIL KUMAR

CHAURASIYA Date: 2018.09.17

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Prakashi v. State of Rajasthan WP NO. 11420/2018

HIGH COURT OF JUDICATURE FOR RAJASTHAN BENCH AT JAIPUR
S.B. Civil Writs No. 6200/2018

Prakashi

---Petitioner

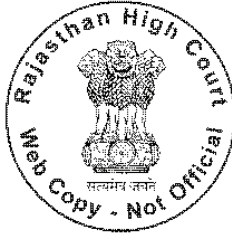
Versus

State Of Raj And Ors

---Respondent

For Petitioner(s): Mr. Sudhindra Kumawat

For Respondent(s):

HON'BLE MR. JUSTICE SANJEEV PRAKASH SHARMA

HON'BLE MR. JUSTICE SANJEEV PRAKASH SHARMA

Order**09/05/2018**

Two weeks' time is granted to remove the defect(s), failing which the writ petition shall stand dismissed automatically without further reference to the

(SANJEEV PRAKASH SHARMA),J

Anu/5

सत्यमेव जयते

CHILD MARRIAGE**Forum for Fact Finding Documentation and Advocacy v. Union of India,
Supreme Court W.P. (C) 212/2003****ITEM NO. 4 COURT NO.6 SECTION PIL**

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS
WRIT PETITION (CIVIL) NO(s). 212 OF 2003

FORUM, FACT FINDING DOCUMENTATION & ADV. Petitioner(s) VERSUS
UNION OF INDIA & ORS. Respondent(s)

With application for interim directions and directions and exemption from filing O.T.) Date: 24/08/2007 This Petition was called on for hearing today.

CORAM : HON'BLE MR. JUSTICE S.B. SINHA
HON'BLE MR. JUSTICE H.S. BEDI

For Petitioner(s) Mr. Colin Gonsalves, Sr.Adv.
Mr. Vipin M., Adv.
Ms. Jyoti Mendiratta,Adv.

For Respondent(s) Mr. G.E.Vahanvati,Solicitor General
Mr. P.P. Mahotra,ASG
Mr. Hrishikesh Baruah,Adv. Ms. Rekha Pandey, Adv.
Ms.Sushma Suri, Adv.

State of Punjab Mr. K.K. Mahalik, Adv. Mr. Kuldip Singh,Adv.

State of Arunachal Mr. Anil Shrivastav,Adv. Pradesh
Mr.Ritu Raj,Adv.

State of Maharashtra	Mr. S. S. Shinde, Adv. Mr. V.N. Raghupathy, Adv.-2-
State of Andhra Pradesh	Mrs. D. Bharathi Reddy, Adv.
State of Kerala	Mr. G. Prakash, Adv. Ms. Beena Prakash, Adv.
State of Haryana	Mr. Manjit Singh, Adv. Mr. T.V. George, Adv. Mr. B.S. Banthia, Adv.(NP) Mr. Ratan Kumar Choudhuri, Adv.
State of Rajasthan	Mr. Aruneshwar Gupta, Adv. Mr. Naveen Kumar Singh, Adv. Mr. Mukul Sood, Adv. Mr. Shashwat Gupta, Adv. Mr. Adarsh Sabharwal, Adv. Mr. Sanjay R. Hegde, Adv. Mr. Prakash Shrivastava, Adv. Mr. Radha Shyam Jena, Adv.(NP) Mr. B.B. Singh, Adv.(NP) Mr. Khwairakpam Nobin Singh, Adv. Mr. Mohanprasad Mehraria, Adv.(NP) Mr. V.G. Pragasam, Adv. Mr. S. Joseph Aristotle, Adv. Mr. S. Prabu Ramasubramanian, Adv. Mrs. Anil Katiyar, Adv. Mr. Ravindra Keshavrao Adsure, Adv.
State of Meghalaya	Mr. Ranjan Mukherjee, Adv. Mr. S.C. Ghosh, Adv. Ms. Rekha Pandey, Adv. Mr. D.S. Mahra, Adv.

State of Assam	Ms. Minakshi Sarma, Adv. for M/s Corporate Law Group, Adv.
State of Sikkim	Mr. Sonam P. Wangdi, A.G. Mr. A. Mariarputham, Adv. Mrs. Aruna Mathur, Adv. for M/s Arputham, Aruna & Co. Ms. Hemantika Wahi, Adv. Ms. Pinky Behera, Adv.
State of Bihar	Mr. Manish Kumar, Adv. Mr. Gopal Singh, Adv. Mr. Anukul Raj, Adv. Mr. Rituraj Biswas, Adv.
State of Tripura	Mr. Manish Kumar, Adv. Mr. Gopal Singh, Adv.
State of Goa	Ms. A. Subhashini, Adv. Mr. J.S. Attri, Adv. Mr. V.K. Sharma, Adv. Mr. H.K. Puri, Adv. Mr. Ujjwal Banerjee, Adv. Mr. S.K. Puri, Adv. Ms. Priya Puri, Adv. Mr. V.M. Chauhan, Adv. Ms. Kamini Jaiswal, Adv. Mr. Anil Shrivatav, Adv. Mr. R. Ayyam Perumal, Adv.
State of Chhattisgarh	Ms. Suparna Srivastava, Adv. Ms. Nidhi Minocha, Adv. Mr. Rajesh Srivastava, Adv. Mr. K.N. Madhusoodhanan, Adv. Mr. R. Sathish, Adv.

Dr. Indra Pratap Singh, Adv.

Mr. Anuvrat Sharma, Adv.

Ms. Vibha Datta Makhija, Adv.

Mr. Altaf H. Naiyak, A.G.

Mr. Anis Suhrawardy, Adv.

Mr. Merusagar Samantaray, Adv.

Mr. Sunny Chowdhary, Adv.

Mr. Vairagya Vardhan, Adv. for

Mr. C.D. Singh, Adv. (NP)

State of Nagaland

Mr. U. Hazarika, Adv.

Mr. Satyamitra, Adv.

Ms. Sumita Hazarika, Adv.

Mr. Ajay Pal, Adv.

UPON hearing counsel the Court made the following ORDER

Having heard learned Solicitor General and Mr. Colin Gonsalves, learned senior counsel, we are of the opinion that the Prohibition of Child Marriage Act, 2006(No.6 of 2007) may be brought into force as expeditiously as possible and preferably within four weeks from date.

It is expected that the States within six weeks, thereafter, shall frame appropriate Rules. Put up after ten weeks.

[Meenu Sethi]

Court Master

[Pushap Lata Bhardwaj]

Court Master

Continued...**ITEM NO.6****COURT NO.5 SECTION PIL**

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS

WRIT PETITION (CIVIL) NO. 212 OF 2003

FORUM, FACT FINDING DOCUMENTATION & ADV.

Petitioner(s) VERSUS

UNION OF INDIA & ORS.

Respondent(s)

(With appln(s) for interim directions and exemption from filing O.T.) Date: 12/11/2007 This Petition was called on for hearing today.

CORAM : HON'BLE MR. JUSTICE S.B. SINHA

HON'BLE MR. JUSTICE H.S. BEDI

For Petitioner(s) Mr. Colin Gonsalves, Sr.Adv.

Mr. Vipin M. Benjamin,Adv.

Ms. Jyoti Mendiratta,Adv.

For Respondent(s) Mr. B. Datta, ASG Mr. C.D. Singh,Adv.

Ms. A.Subhashini ,Adv

Mr. Aruneshwar Gupta ,Adv

Mr. Naveen Kumar Singh,Adv.

Mr. Sashwat Gupta,Adv.

Mr. Sanjay R. Hegde,Adv.

Mrs Anil Katiyar ,Adv

Mr. Altaf H. Nayak,Adv.

Gen. Mr. Anis Suhrawardy ,Adv

Mrs. Shamama Anis,Adv.
Mr. S. Mehdi Imam,Adv.
Mr. B.B. Singh ,Adv
Mr. P. Krishnamurthy, Sr.Adv.
Mr. G. Prakash ,Adv
Ms. Beena Prakash,Adv.
Mr. P.K. Jayakrishnan,Adv.
Mr. K.A. Devarajan,Adv.
Mr. Ritu Raj Biswas,Adv.
Mr. Gopal Singh ,Adv
Mr. Gopal Singh,Adv.
Mr. Anukul Raj,Adv.
Mr. H.K. Puri ,Adv
Mr. U. Banerjee,Adv.
Mr. V.M. Chauhan,Adv.
Mrs. Priya Puri,Adv.
Ms. Hemantika Wahi ,Adv.
Miss Shivangi,Adv.
Ms. Kamini Jaiswal ,Adv
Mr. R. Sathish ,Adv
Mr. A. Mariaputha,Adv.
Ms. Aruna Mathur,Adv. for
M/S. Arputham,Aruna & Co.,Advs.
Mr. R. Ayyam Perumal ,Adv
Mrs. Rekha Pandey,Adv.
Mr. D.S. Mahra ,Adv
Mr. Ranjan Mukherjee ,Adv
Mr. V.G. Pragasam ,Adv
Mr. S. Jolseph Aristotle,Adv.
Mr. S. Prabu Ramsubramanian,Adv.

Mr. J.S. Attri ,Adv
Mrs. Jayshree Anand,Adv.
Mr. K.K. Mahalik,Adv.
Mr. Ajay Pal,Adv.
Mrs. D. Bharathi Reddy ,Adv
Mr. Khwairakpam Nobin Singh ,Adv
Mr. Tarun Jamwal,Adv. Mr. Biswajit Meitei,Adv.
Mr. Radha Shyam Jena ,Adv
Mr. Prakash Shrivastava ,Adv
Mr. Anil Shrivastav ,Adv
Mr. Sanjay R. Hegde,Adv.
Mr. Amit Kr. Chawla,Adv.
Mr. Ratan Kumar Choudhuri ,Adv
Mr. Riku Sarma,Adv.
for M/S. Corporate Law Group ,Adv.
Ms. Suparna Srivastava,Adv.
Mr. Rajesh Srivastava ,Adv
Ms. Simanti Chakrabarti,Adv.
Ms. Vibha Datta Makhija ,Adv
Mr. Philemon Nongbri,Adv.
Mr. Ravindra Keshavrao Adsure ,Adv
Mr. T.V.George ,Adv.
Mr. Upamanyu Hazarika,Adv.
Mr. Satya Mitra,Adv.
Ms. Sumita Hazarika ,Adv.
Dr. Inra Pratap Singh,Adv.
Mr. Anuvrat Sharma,Adv.

UPON hearing counsel the Court made the following ORDER

Learned Additional Solicitor General has placed before us a notification dated October 30, 2007,

notifying the 1st day of November, 2007 as the appointed day in regard to the coming into force of the Prohibition of Child Marriage Act, 2006. Let the matter appear 12 weeks hence. In the meantime, it is expected that the States shall frame the rules in terms of the provisions of the said Act.

(A.S. BISHT)

COURT MASTER

(PUSHAP LATA BHARDWAJ)

COURT MASTER

Society for Enlightenment and Voluntary Action and Anr. Vs. Union of India and Ors. 2017

ITEM NO.15

COURT NO.4 SECTION PIL-W

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS

Writ Petition(s)(Civil) No(s). 1234/2017

SOCIETY FOR ENLIGHTENMENT AND VOLUNTARY ACTION & ANR. Petitioner(s)

VERSUS

UNION OF INDIA & ORS.

Respondent(s) (FOR ADMISSION)

Date : 09-01-2018 This petition was called on for hearing today.

CORAM : HON'BLE MR. JUSTICE MADAN B. LOKUR
 HON'BLE MR. JUSTICE DEEPAK GUPTA

For Petitioner(s)

For Respondent(s) Ms.Sneha Mukherjee, Adv.
 Mr.Deepak Kr. Singh, Adv.
 Mr.Satya Mitra, AOR

UPON hearing the counsel the Court made the following

O R D E R

Learned counsel for the petitioners seeks four weeks' time to file additional affidavit.
List immediately after the additional affidavit is filed.

(Ashok Raj Singh)
Court Master

(Kailash Chander)
Court Master

Continued...

ITEM NO.9

COURT NO.4 SECTION PIL-W

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS
Writ Petition(s)(Civil) No(s).1234/2017

SOCIETY FOR ENLIGHTENMENT AND VOLUNTARY ACTION & ANR. Petitioner(s)

VERSUS

UNION OF INDIA & ORS. Respondent(s)

Date : 13-04-2018 This petition was called on for hearing today.

CORAM : HON'BLE MR. JUSTICE MADAN B. LOKUR
 HON'BLE MR. JUSTICE DEEPAK GUPTA

For Petitioner(s) Ms. Sneha Mukherjee, Adv.
 Mr. Satya Mitra, AOR

For Respondent(s)

UPON hearing the counsel the Court made the following

O R D E R

The issue raised in this writ petition is with regard to the implementation of the Prohibition of Child Marriage Act, 2006.

The contention of the petitioners is that the Act is not being implemented in letter and spirit.

Issue notice to the Union of India (Respondent No.1) returnable in four weeks.

Dasti, in addition, is permitted.

Signature Not Verified

(SANJAY KUMAR-I)
AR-CUM-PS

(SAROJ KUMARI GAUR)
COURT M

Continued...

ITEM NO.10

COURT NO.4 SECTION PIL-W

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS
Writ Petition(s)(Civil) No(s). 1234/2017

SOCIETY FOR ENLIGHTENMENT AND VOLUNTARY ACTION & ANR. Petitioner(s)

VERSUS

UNION OF INDIA & ORS.

Respondent(s)

Date : 11-05-2018 This petition was called on for hearing today.

CORAM : HON'BLE MR. JUSTICE MADAN B. LOKUR
HON'BLE MR. JUSTICE DEEPAK GUPTA

For Petitioner(s) Mr. Colin Gonsalves, Sr. Adv.
Ms. Sneha Mukherjee, Adv.
Mr. Satya Mitra, AOR
Mr. Deepak Kr. Singh, Adv.

For Respondent(s) Ms. Pinky Anand, ASG
Mrs. Madhavi Divan, Adv.
Ms. Snidha Mehra, Adv.

UPON hearing the counsel the Court made the following

O R D E R

Counter affidavit be filed during the course of the day. Rejoinder, if any, be filed thereafter.

The Registry will not accept any affidavit filed by any other State since notice has been issued only to the Union of India.

(MEENAKSHI KOHLI)

COURT MASTER

(CHANDER BALA)

COURT MASTER

Jago Foundation vs. the Union of India W.P(PIL) No. 5406 of 2013

IN THE HIGH COURT OF JHARKHAND AT RANCHI

W.P(PIL) No. 5406 of 2013

Jago Foundation, through its Secretary, Baidyanath Mahto, S/o Bishwanath Mahto, R/o Village-Guro, P.O-Senadoni, P.S-Giridih Muffassil,
District- Giridih, Jharkhand

...Petitioner

Versus

1. Union of India, through its Secretary, Ministry of Women and Child Development, New Delhi
2. Ministry of Health & Family Welfare, New Delhi
3. State of Jharkhand, through its Secretary, Department of Social Welfare, Women and Child Development, Ranchi Respondents

For the Appellant : Mr. A.K.Agarwal Advocate

For the Respondents : Mr. Rajesh Kumar, Advocate

CORAM :

HON'BLE MR. JUSTICE VIRENDER SINGH, CHIEF JUSTICE

HON'BLE MR. JUSTICE SHREE CHANDRASHEKHAR

Order No.13/Dated 10th February, 2016

1. Initially, the writ petition was filed for a direction upon the respondent-State of Jharkhand to appoint a full-time Child Marriage Prohibition Officer under Section 16(1) of the Prohibition of Child Marriage Act, 2006 and for a direction for framing Rules under Section 19 of the

Act. During the pendency of the writ petition, the State Government issued notification dated 11.06.2007 designating the Block Development Officer in each Block as the Child Marriage Prohibition Officer and, vide notification dated 23.04.2015, the Jharkhand Child Marriage Prohibition Rules, 2015 have also been notified.

2. Mr. A.K. Agarwal, the learned counsel for the petitioner-Jago Foundation submits that in view of the incognizable steps taken by the State Government for effective implementation of the Prohibition of Child Marriage Act, 2006, detail guidelines may be issued by the Court. Referring to the counter affidavit dated 20.08.2014 filed on behalf of the respondent-State Government, the learned counsel for the petitioner points out that except, organizing a State Level Consultation on 06.09.2012, the respondent-State has not taken any step in the matter and, in fact, even the details of the aforesaid State Level Consultation have not been brought on record. It is stated that in the last five years, hundreds of child marriages in violation of the prohibition under the 2006 Act have been performed in the State of Jharkhand however, unmindful of their statutory duty the respondents have not taken proper and effective step in the matter.
3. Without delving deep in the history, we notice that amongst Hindus, child marriage was prevalent in abundance and such marriage was even recognized as valid. The ill-effect of the child marriage was noticed even during the colonial period and there was no mechanism to discourage child marriages. The Child Marriage Restrain Act, 1929 was enacted to restrain child marriages and to carry forward the reformist movement for eradicating the evil of child marriage. However, over a period it was felt that the provisions of 1929 Act should be made more effective and to effectively prevent the evil practice of child marriages in the country, stringent punishment should be provided. The National Commission for Women in its annual report for the year 1995-96 recommended that the Government should appoint the Child Marriage Prevention Officers immediately. The Commission also recommended that, (i) the punishment provided under the Act should be more stringent; (ii) marriages performed in contravention of the Act should be made void; and (iii) the offences under the Act should be made cognizable. The National Human Rights Commission also undertook a comprehensive review of the existing Act and made recommendations for comprehensive amendment in its annual report 2001-02. Accepting the recommendations and after consulting the State Governments and the Union Territories' Administrations, the Central Government repealed the 1929 Act and enacted the Prohibition of Child Marriage Act, 2006.
4. Rule 4 of the "Jharkhand Child Marriage Prohibition Rules, 2015" provides that awareness through different media and incentive for active role played by the members of civil society, PRI and socially concerned citizen are few steps which have to be taken. Rule 4(3) provides that the District Magistrate may pass an order under sub-section (5) of Section 13 of the Act directing all or any police station to keep vigil at religious and public places. The rule also enjoins the District Magistrate to take appropriate action to check and prevent the solemnization of child marriages especially, during special occasions when mass child marriages are solemnized.

5. A report prepared by the United Nations Population Fund (UNPF) discloses that in child marriage the Jharkhand is among the top three States in the country. According to Annual Health Survey of 2010-11, Jharkhand is only behind Bihar and Rajasthan where 51.8% girls below 18 years were married. The National Family and Health Survey-III Report of 2005-06 indicates that 63.2% women in Jharkhand got married before 18 years; the percentage however, fell to 55.7% in 2007-08 Survey-III report.
6. In the aforesaid facts, considering the indifferent response of the respondents-authorities, we hereby issue the following directions:
 - (i) State Government shall appoint Child Prohibition Officer for each District for entrusting him with the duties and liabilities under Jharkhand Child Marriage Prohibition Rules, 2015;
 - (ii) Child Welfare Committee constituted under Section 27 of the Juvenile Justice (Care & Protection of Child) Act, 2015 for every District shall coordinate with Child Marriage Prohibition Officer for effective implementation of the Prohibition of Child Marriage Act, 2006 and for protecting the best interest of the child;
 - (iii) A complete mechanism shall be evolved by District Magistrates of each District of the State for entertaining the complaints and action thereon in terms of Jharkhand Child Marriage Prohibition Rules, 2015;
 - (iv) District Magistrate shall pass necessary directions under Sub Section (5) of Section 13 to all the Police Stations falling within his jurisdiction to keep vision at religious and public places and also to take appropriate action to check and prevent the solemnization of child marriages, especially during special occasions when mass child marriages are solemnized;
 - (v) Keeping in view the sensitivity of the issue, District Magistrate, in terms of Rule 4 of Jharkhand Child Marriage Prohibition Rules, 2015 shall ensure that awareness through different media is made in this regard involving members of civil society/PRI and socially concerned citizen by calling them and providing incentive for their active role in bringing the matter to the concerned authority;
 - (vi) Jharkhand State Legal Services Authority (for short 'JHALSA') shall also step in and ensure that it reaches out to the masses by organising awareness camps at different levels involving District Legal Services Authority (DLSA), Taluk Legal Services Authority (TLSA) and the District Administration.
7. Registry is directed to supply a copy of the order to the Member Secretary, JHALSA for perusal by Hon'ble the Executive Chairperson of JHALSA. A copy of the order shall also be communicated to the Chief Secretary of the State for its compliance.
8. Disposed of.

(Virender Singh, C.J.) (Shree Chandrashekhar, J.) Satish/LAK

Himmat Mahila Samooh vs. Union of India & Ors CWP No. 24703 of 2015

IN THE HIGH COURT OF PUNJAB AND HARYANA
AT CHANDIGARH

CWP No. 24703 of 2015

DATE OF DECISION : 02.12.2015

Himmat Mahila Samooh

.... PETITIONER

Versus

Union of India and others

.... RESPONDENTS

CORAM : HON'BLE MR. JUSTICE SATISH KUMAR MITTAL
HON'BLE MR. JUSTICE SHEKHER DHAWAN

Present : Ms. Veena Kumari, Advocate,
for the petitioner.

SATISH KUMAR MITTAL, J. (Oral) After going through the order dated 20.02.2014 (Annexure P-1) passed by the Government on the direction issued by this court on a writ petition (CWP No. 1262 of 2014) filed by the petitioner, we find that various steps have been taken to improve the TFR (Total Fertility Rate). For that purpose, the policies have been evolved and expanded to educate and motivate people and make available different methods of contraception. Sterilisation Camps are being organised. The usage of Intrauterine Contraceptives Devices has improved over the years. Sufficient stock of contraceptives are supplied from the State Headquarter and resultantly, the TFR (Total Fertility Rate) has been reduced, and there is definite improvement in the unmet need of contraceptives in the State of Haryana. DASS NAROTAM 2015.12.03 11:18 I attest to the accuracy and authenticity of this document In view of the above, we do not

find any reason to issue further direction at this stage, as the Government has already taken the requisite steps.

Dismissed.

(SATISH KUMAR MITTAL)

JUDGE

December 02, 2015

(SHEKHER DHAWAN)

ndj

JUDGE

Bihar Voluntary Health Association vs Union of India & Ors W P (C) No 000456/2018

REGISTRAR COURT. 2

SECTION PIL-W

SUPREME COURT OF INDIA
RECORD OF PROCEEDINGS

BEFORE THE REGISTRAR RAJESH KUMAR GOEL

Writ Petition(s)(Civil) No(s). 456/2018

BIHAR VOLUNTARY HEALTH ASSOCIATION

Petitioner(s)

VERSUS

UNION OF INDIA & ORS.

Respondent(s)

Date : 22-04-2019 This petition was called on for hearing today.

For Petitioner(s) Ms. Sneha Mukherjee,Adv.

Mr. Satya Mitra, AOR

For Respondent(s) Mr. Santosh Prasad Chaurasiya,Adv.

Mr. Gurmeet Singh Makker, AOR

Mr. K.V. Jagdishvaran,Adv. Ms. G. Indira, AOR

Ms. Astha Sharma,Adv. Ms. Dimple Nagpal,Adv.

M/S. PLR Chambers And Co., AOR Ms. Hemantika Wahi, AOR

Ms. Giss Antony,Adv.

Mr. Samir Ali Khan, AOR Mr. Siddhesh Kotwal, Adv.

Ms. Astha Sharma, Adv.

Mr. Abhimanyu Jhamba, Adv.

Ms. Hemlata Ranga, Adv.

Mr. Samir Ali Khan, Adv.

Mr. Shashank Garg, Adv.

Mr. Jariq Khan, Adv.

Ms. Aastha Jain, Adv.

UPON hearing the counsel the Court made the following

O R D E R

The office report indicates that respondent Nos. 1, 2, 9 and 33 have not filed counter affidavit in terms of order dated 30.1.2019 of the Hon'ble Court.

Perused the record. It is evident that vide order dated 30.1.2019, Hon'ble Court has been pleased to issue notice with a direction that counter affidavit be filed within four weeks from the date of the order. It was also directed that matter be listed after four weeks.

Vakalatnama appears to have been filed on behalf of respondent Nos. 1, 2, 9 and 33 but till date counter affidavit has not been filed. Ld. Counsel for respondent No.9 submit that he has not received the complete set of pleadings. Learned counsel for petitioner is directed to provide the copies of the pleadings to the learned counsel for said respondent within a weeks' time and file proof.

Ld. Counsel for respondent No.1 submits that he has already filed the vakalatnama and counter affidavit. Registry is directed to verify the same and report accordingly.

Service of notice is complete qua respondent Nos. 3, 5, 7, 8, 10 to 17, 19-26, 28-32 but no one has entered appearance on their behalf.

Ld. Counsel for respondent Nos.11 and 13 submits that he has already filed the vakalatnama. Registry to verify the same.

Mr. Siddhesh Kotwal, Ld. Counsel appearing on behalf of Ms. Astha Sharma, Ld. Advocate-on-Record seeks and is given two weeks' time to file the vakalatnama and four weeks' time to file the counter affidavit on behalf of respondent No.21 (State of Mizoram).

The office report indicates that the vakalatnama filed by the learned counsel for the respondent No.6 is defective. The learned counsel shall within a period of four weeks cure the defects whatever have been found in the said vakalatnama.

As per postal tracking report, notice issued to respondent Nos. 4 and 8 could not be served and returned back undelivered. Hence, learned counsel for petitioner shall, within a period of four weeks', file fresh particulars of the said respondents and shall take requisite steps for the service of notice upon them and in respect of respondent No.27 through the Ld. Standing Counsel representing the State.

Appearing respondents are free to file the counter affidavit in terms of the order of Hon'ble Court dated 30.1.2019.

List again on 18.9.2019.

RAJESH KUMAR GOEL

Registrar

MG

Sarita Barpanda vs. Union of India and ORS

§-28

* IN THE HIGH COURT OF DELHI AT NEW DELHI
+ W.P.(C) 5541/2019 & CM APPL.24304/2019

SARITA BARPANDA

..... Petitioner

Through: Mr. Deepak Kumar Singh, Adv.

versus

UNION OF INDIA AND ORS.

..... Respondents

Through: Mr. Rushila Rebello, Adv.

O R D E R

% 21.05.2019

The Hon'ble Division Bench-I (Coram: Hon'ble the Chief Justice and HMJ Anup Jairam Bhambhani) could not assemble today.

List on 08.07.2019.


BY ORDER
(COURT MASTER)

MAY 21, 2019

ns

Preventable Maternal Deaths

Bharat Sahoo vs. Union of India W.P. (C) No. 17958 of 2016, In the High Court of Orissa, Cuttack


IN THE HIGH COURT OF ORISSA, CUTTACK
 W.P. (C) No. 17958/2016
 Code No. 079900

In the matter of

An application under Article 226 and 227 of the Constitution of India.

And

In the matter of;

An application relating to death of Smt. Renubala Sahoo a pregnant lady due to denial of services, inaction of state authorities and non implementation of the welfare schemes framed by the department of Health & Family Welfare and Women and Child Development Department.

Presented in Court
K. S. Dhat
B.O.

And


In the matter of;

Bharat Sahoo, aged about 29 years, S/O-Maharag Sahoo, At/PO- Belbahali, P.S. – Ghasipura, Dist-Keonjhar.

....Petitioner

Versus

1. State of Orissa represented through its Commissioner-Cum-Secretary, Health & Family Welfare Department, Secretariat Building, Bhubaneswar, Dist- Khurda


Surendra Prasad Dhat
 Advocate
 NOTARY. CUTTACK
2/7/2016

2



2. Union of India represented through its Commissioner-
Cum-secretary, Women & Child Welfare Department,
New Delhi.
3. Commissioner- Cum- Secretary, Women & Child Welfare
Department, Secretariat Building, Bhubaneswar, Dist-
Khurda.
4. Mission Director, National Health Mission, Odisha
Nayapalli, Bhubaneswar, Dist- Khurda.
5. Collector-Cum-Chairman, Zilla Swasthya Samiti,
Keonjhar, At/Po/Dist-Keonjhar.
6. Chief District Medical Officer, Keonjhar
At/PO/Dist-Keonjhar.

... Opposite Parties.



16

[O. H. C.-98]

W.P.(C) No.17958 of 2016

Sl. No. of Order	Date of Order	ORDER WITH SIGNATURE	Office note as to action (if any), taken on Order
02.	22.11.2016	<p>Heard learned counsel for the petitioner and learned Additional Standing Counsel for the State.</p> <p>Considering the contentions of learned counsels for both the parties and pleadings, limited grievance being there for ex-gratia compensation, the writ petition is disposed of with a direction to the petitioner to make a fresh representation enclosing all the documents and certified copy of this order to the opposite party No.5-Collector-cum-Chairman, Zilla Swasthya Samiti Keonjhar within a period of three weeks from today and the opposite party No.5 would do well to consider and dispose of the representation after giving proper opportunity to the petitioner of being heard within a period of two months from the date of receipt of the representation and communicate the decision to the petitioner. It is needless to say that the opposite party No.5 will pass a speaking order while disposing of the representation of the petitioner.</p> <p>Urgent certified copy of this order be granted on proper application.</p>	<p>Sl. Dr. D. P. Choudhury, J.</p> <p>Comp by: [Signature] 24/11/16</p>



Moba Changkai versus State of Nagaland & Ors, Writ Petition No. 179 (K) of 2016 Guwahati High Court, Kohima Bench

1

IN THE GAUHATI HIGH COURT
(HIGH COURT OF ASSAM: NAGALAND: MIZORAM & ARUNACHAL PRADESH)
KOHIMA BENCH

W.P.(C) No. 179(K) of 2016

Moba Changkai .. Petitioner
Vs ..
The State of N/L & 8 Ors. .. Respondents

PRESENT
THE HON'BLE MR. JUSTICE S. SERTO

For the Petitioner : Kezhosano Kikhi
Vinika Kiho
Minlum, Advs.

For the Respondent : Govt. Adv. N/L
Yangerwati, CGC for R/No.9
N. Mozhui for R/No.3 & 4.

24.01.2017 **ORDER**

I have heard Ms. K. Kikhi, learned counsel appearing for the petitioner and I have also heard Mr. K. Sema, learned Sr. Addl. A.G. who appears on behalf of respondent Nos. 1,2,5,6,7 & 8, Mr. L. Likhase, learned counsel who appears on behalf of Mr. N. Mozhui learned counsel for the respondent Nos. 3 & 4 and Mr. Yangerwati, learned CGC who appears on behalf of respondent No.9. Mr. K. Sema, learned Sr. Addl. A.G. is given time to file counter affidavit and at the same time to come with instruction on the interim prayer.


List it after 4(four) weeks.

Let a copy of this order be furnished to Mr. K. Sema, learned Sr. Addl. Advocate General.

Sd/- JUDGE

TRUE COPY
31/1/17
Administrative Officer (Judicial)
Gauhati High Court
Kohima Bench

Alin Kumar Sasmal vs. State of Orissa & Others W.P. (C) No. 5428 of 2016, In the High Court of Orissa, Cuttack


 IN THE HIGH COURT OF ORISSA, CUTTACK
 (ORIGINAL JURISDICTION CASE)
 W.P. (C) No. 5428 Of 2016
 Code No - 079900

In the matter of: An application under Articles 226 and 227 of the constitution of India.

And

In the matter of: An application for appropriate direction for proper and meaningful implementation of necessary provisions of the National Food Security Act 2013 in its true spirit and proper implementation of Welfare Schemes meant for pregnant women and new –born children floated by Ministry of Women and Child Development such as Integrated Child Development Scheme and all such other schemes floated by Ministry of Health and Family Welfare, Government of India and Department of Health & Family Welfare, Government of Orissa such as National Health Mission, Janani Surakhya Yajana, Mamata, and other women and children beneficial schemes & Strict implementation of the Clinical Establishment (Control & Regulation) Act 1990 and Violation of The Indian Medical Council (Professional Conduct, Etiquette & Ethics) Regulations, 2012.

Presented In Court
[Signature]
B.O.
July 14


And

In the matter of: An application relating to death of Gauri Sasmal, a pregnant lady due to denial of services at right time, in-action of state and non-implementation of the welfare schemes by the department of Health & Family Welfare and Department of Women and Child Development.

And

In the matter of: Sri. Alin Kumar Sasmal, aged about 33 years, S/O Priyanath Sasmal, resident of village / P.O- Kainagari, P.S-Singla, Dist – Baleswar in the state of Odisha.

..... Petitioner.
[Signature]



-Versus-

- 1) State of Orissa Represented through its Commissioner cum Secretary, Health & Family Welfare Department, State Secretariat, Bhubaneswar, Dist-Khurda, Odisha.
- 2) State of Orissa Represented through its Commissioner cum Secretary, Women & Child Welfare Department, State Secretariat, Bhubaneswar, Dist-Khurda. Odisha.
- 3) Mission Director, National Health Mission, Odisha Nayapalli, Bhubaneswar, Dist – Khurda.
- 4) Collector Cum Chairman, Zilla Swasthya Samiti, Baleswar. At/P.O/P.S / Dist – Baleswar.
- 5) Chief District Medical Officer, Baleswar, AT/P.O/ P.S / Dist – Baleswar.

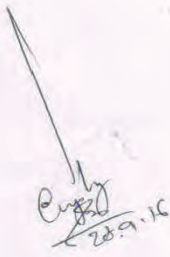
..... Opposite Parties.



2018
28/9

[O. H. C.-98]

W.P.(C) No.5428 of 2016

Sl. No. of Order	Date of Order	ORDER WITH SIGNATURE	Office note as to action (if any), taken on Order
	2. 26.9.2016	<p>Heard learned counsel for the petitioner and learned Addl. Standing Counsel.</p> <p>Issue notice.</p> <p>Five extra copies of the brief be served on learned Addl. Standing Counsel on behalf of the opp. parties. Learned Addl. Standing Counsel seeks time to obtain instruction in the matter.</p> <p>List this matter on 26.10.2016</p> <p style="text-align: right;">Sd/- Dr. D. P. Choudhury, J.</p> <p style="text-align: center;">  </p>	



Sahab Uddin Mazumdar Vs. State of Assam & ors. WP(C) 8645/2018**GAHC010276132018**

THE GAUHATI HIGH COURT

(HIGH COURT OF ASSAM, NAGALAND, MIZORAM AND ARUNACHAL PRADESH)

Case No. : WP(C) 8645/2018

1:SAHAB UDDIN MAZUMDAR

S/O LATE FORMUJ ALI MAZUMDAR, R/O VILL- GONIRGRAM PART-IV,

P.O. GONIRGRAM

DIST. CACHAR, ASSAM, PIN - 788025.

VERSUS

1:THE STATE OF ASSAM AND 5 ORS.

REP. BY THE COMMISSIONER AND SECRETARY TO THE GOVT. OF ASSAM, HEALTH
AND FAMILY WELFARE (A) DEPARTMENT,
DISPUR, GUWAHATI , ASSAM, PIN- 7810062:THE DIRECTOR OF HEALTH SERVICES DIRECTORATE OF HEALTH SERVICES
GOVT. OF ASSAM HENGRABARI GUWAHATI - 781036 ASSAM3:THE MISSION DIRECTOR NATIONAL HEALTH MISSION SAIKIA COMMERCIAL
COMPLEX

SREENAGAR ROAD NEAR POST OFFICE CHRISTIAN BASTI GUWAHATI

ASSAM

PIN - 781005

4: MEDICAL OFFICER

FULBARI PRIMARY HEALTH CENTER

SRIPUR PART-I DIST. CACHAR ASSAM

PIN - 788025

5:THE COMMISSIONER AND SECRETARY

THE DEPARTMENT OF PANCHAYAT AND RURAL DEVELOPMENT C BLOCK

2ND FLOOR

ASSAM SECRETARIAT GUWAHATI

ASSAM

PIN - 781006.

6:THE DEPUTY COMMISSIONER CACHAR

SILCHAR DIST. CACHAR ASSAM

PIN 788001

Advocate for the Petitioner:

MS. D GHOSH

Advocate for the Respondent :

GA, ASSAM

BEFORE

HONOURABLE MR. JUSTICE UJJAL BHUYAN

ORDER

Date : 11-01-2019

Heard Ms. D Ghosh, learned counsel for the petitioner. Issue notice, returnable within 8 weeks.

Ms. A Bora, learned Standing Counsel, Health Department, Assam accepts notice on behalf of respondent Nos.1 to 4. Mr. M Nath, learned counsel for the Panchayat and Rural Development Department, Assam accepts notice on behalf of respondent No.5. Mr. D Das

Barman, learned Government Advocate, Assam accepts notice on behalf of respondent No.6.
Extra copies within 3 days.

List again on 25.03.2019 showing the names of learned counsel for the parties.

JUDGE

Biplab

Comparing Assistant

2

7. Chief District Medical Officer, Nuapara
At/PO/Dist-Nuapara.

... Opposite Parties.

The matter out of which this petition arises was never before this Hon'ble Court in



C.-98]

W.P.(C) NO.20992 of 2018

Sl. No. of Order	Date of Order	ORDER WITH SIGNATURE	Office note as to action (if any), taken on Order
02.	30.04.2019	<p>Heard.</p> <p>The petitioner is stated to have filed a representation vide Annexure- 4 before the Collector-cum-Chairman, Zilla Swasthya Samiti, Nuapara- Opposite Party No.6 for redressal of her grievance. The said representation is stated to be still pending.</p> <p>Taking into consideration the facts and submissions and without going into the merit of the case, the writ application is disposed of, directing the Collector-cum-Chairman, Zilla Swasthya Samiti, Nuapara-Opposite Party No.6, to dispose of the representation of the petitioner vide Annexure- 4 in within a period of two months from the date of receipt of a certified copy of this Order.</p> <p>The petitioner is directed to supply a copy of the writ application containing all the Annexures along with a certified copy of this Order to the Opposite Party No.6 for convenience & reference to Annexure-4.</p> <p>The writ application is accordingly disposed of.</p> <p>Urgent certified copy of this order be granted as per rules.</p>	

Subha

Sd/- C.R. Dash, J.

Handwritten signature and initials, possibly 'S.R.S-19', with a checkmark and a downward arrow pointing to the signature area.

Jaya Beshra vs Union of India vs. ORS W.P.(C) No. 20993/2018

IN THE HIGH COURT OF ORISSA, CUTTACK

W.P. (C) No. 20993 / 2018

Code No. 079900

In the matter of

An application under Article 226 and 227 of the
Constitution of India.

And

In the matter of:

An application relating to death of Late Ramani Beshra, a
pregnant women due to denial of services, in-action of the
state and non implementation of the welfare schemes meant
for pregnant women and new born children by the
department of Health and Family welfare and Women and
Child Development Department such as National Health
Mission, Janani Surakhya Yajana, Janani Shishu Surakhya
Karyakram, Mamata Scheme and others.

In the matter of:

Jaya Beshra, aged about 38 years, S/O- Shuarkha Beshra,
At- Jarelpadar, P.O- Bharuamunda, P.S.- Sinapali, Dist-
Nuapara.

...Petitioner

Versus

1. Union of India represented through its Commissioner-Cum
Secretary, Health & Family Welfare Department, Secretariat
Building, Bhubaneswar, Dist- Khurda.
2. Union of India represented through its Commissioner-Cum-
Secretary, Women & Child Welfare Department, New Delhi.

2

12/12/18 B.O.

Sfm
ACW

12-12-2018

2

3. State of Orissa represented through its Commissioner-Cum-Secretary, Health & Family Welfare Department, Secretariat Building, Bhubaneswar, Dist- Khurda.
4. State of Orissa Commissioner- Cum- Secretary, Women & Child Welfare Department, Secretariat Building, Bhubaneswar, Dist- Khurda.
5. Mission Director, National Health Mission, Odisha Nayapalli, Bhubaneswar, Dist- Khurda.
6. Collector-Cum-Chairman, Zilla Swasthya Samiti, Nuapara, At/Po/Dist-Nuapara.
7. Chief District Medical Officer, Nuapara At/PO/Dist-Nuapara.

...Opposite Parties.



-98]

W.P.(C) NO.20993 of 2018

No. of Order	Date of Order	ORDER WITH SIGNATURE	Office note as to action (if any), taken on Order
02.	30.04.2019	<p>Heard.</p> <p>The petitioner is stated to have filed a representation vide Annexure- 4 Series before the Collector-cum-Chairman, Zilla Swasthya Samiti, Nuapara-Opposite Party No.6 for redressal of his grievance. The said representation is stated to be still pending.</p> <p>Taking into consideration the facts and submissions and without going into the merit of the case, the writ application is disposed of, directing the Collector-cum-Chairman, Zilla Swasthya Samiti, Nuapara-Opposite Party No.6, to dispose of the representation of the petitioner vide Annexure- 4 Series in within a period of two months from the date of receipt of a certified copy of this Order.</p> <p>The petitioner is directed to supply a copy of the writ application containing all the Annexures along with a certified copy of this Order to the Opposite Party No.6 for convenience & reference to Annexure-4 Series.</p> <p>The writ application is accordingly disposed of.</p> <p>Urgent certified copy of this order be granted as per rules.</p>	



Subha

Sd/- C. R. Dash, J.

Comp. by Adm
09.05.19

VIOLATION OF MATERNAL HEALTH RIGHTS

- Implementation of Maternity Benefit Schemes- JSK/ JSSY/ PMMVY

Bilkis & Anr versus Gov't of NCT of Delhi & Ors. W.P (C) 4200/2015

\$~25

* IN THE HIGH COURT OF DELHI AT NEW DELHI

+ W.P. (C) 4200/2015

BILKIS & ANR

..... Petitioner

Through: Ms. Sija Nair Pal with Ms. Deepak Kr. Singh, Advocates.

versus

GOVT OF NCT OF DELHI & ORS

..... Respondents

Through: Mr. Naushad Ahmad Khan, ASC (Civil), GNCTD with Mr. Zahid Hanief, Advocate.

Mr. Mukesh Gupta with Ms. Shashi Gupta, Advocates for North DMC/R-6.

Proxy for Mr. Anurag Ahluwalia, Advocate for R-3.

CORAM: HON'BLE MR. JUSTICE RAJIV SHAKDHER

ORDER

% 19.03.2018

1. Neither has order dated 22.2.2018 been complied with nor is the Secretary, Department of Social Welfare present in the Court.

2. Mr. Naushad Ahmad Khan seeks one last accommodation.
3. Renotify the matter on 21.3.2018.
4. Dasti, under the signatures of Court Master.
5. Copy of the order dated 22.2.2018 shall also be given under the signatures of Court Master.
6. In addition thereto, the respondents will also bring the medical records of the deceased Ms. Tabassum to the Court on the next date of hearing.

RAJIV SHAKDHER, J

MARCH 19, 2018/vikas/

**Anthony Debbarma versus the State Of Tripura and Ors WP(C) (PIL)
NO.13/2016**

WP(C)(PIL) NO.13/2016

BEFORE

HON'BLE THE CHIEF JUSTICE MR. T. VAIPHEI

HON'BLE MR. JUSTICE S. TALAPATRA

Present:

For the petitioner: Mr. M. Debbarma, Advocate.

For the respondents: Mr. T.D. Majumder, G.A.,
Mr. Biswanath Majumder, CGC.

13.06.2017.

Heard Mr. M. Debbarma, the learned counsel for the petitioner. Also heard Mr. T.D. Majumder, the learned Govt. Advocate appearing for the State-respondents.

This PIL is about directing the respondents to implement the Janani-Shishu Suraksha Karyakram (JSSK) in letter and spirit and to completely put an end to user fees for pregnant women delivering in public health facilities of Tripura.

The learned State Counsel draws our attention to the memorandum dated 28.12.2016 annexed to the additional affidavit filed on 12.06.2017 and submits that the Clause therein which says that in no case there should be any need for mother to pay the driver and reimbursed later on; money is to be given to the driver by Health facility directly by cheque. According to him, those provisions have now taken care of the grievances of the petitioner. It may also be noted that under Clause 2.2 of the same memorandum, it has been stated as follows:-

“2.2 Drugs and Consumables:

- All required drugs and consumables for pregnant mother during ANC, INC and

PNC are already included in State Essential Drug List (EDL) and made available completely free. In addition, unit cost of Rs.500/- for normal delivery and Rs.1600/- for C-Section delivery as per

estimated no. of ANC cases and Rs.200/- in case of sick infants is by and large provisioned to supplement incidental requirement only. It is an indicative allocation for calculation purpose.

- Only in exceptional case concerned Health facility may locally procure certain JSSK drugs and consumables from the above allotted funds as per procedure. In no case mothers or sick infants shall be allowed to procure the drugs and consumables and later be reimbursed.
- In case of local purchase to meet incidental requirement of drugs & consumables, the same have to be uploaded into the SCMS portal.”

In the light of these two developments, this PIL does not survive for consideration and is accordingly disposed of by directing the State-respondents to implement in letter and spirit the aforesaid Clauses in the memorandum dated 28.12.2016.

JUDGE

CHIEF JUSTICE

Pulak

K. Pradipkumar vs. Union of India & Ors, PIL No. 25 of 2015

IN THE HIGH COURT OF MANIPUR AT IMPHAL

PIL NO. 25 OF 2015

K. Pradipkumar

... Petitioner.

-Versus-

Union of India & 3 Ors.

... Respondents.



BEFORE

HON'BLE THE CHIEF JUSTICE
HON'BLE MR. JUSTICE KH. NOBIN SINGH

For the Petitioners : Mr. M. Rakesh, Advocate

For the Respondents : Mr. R.S. Reisang, Senior G.A.
Mr. S. Rupachandra, ASG

Date of order : 27.02.2017

O R D E R

CJ

Heard Mr. M. Rakesh, learned counsel appearing for the petitioner and Mr. R.S. Reisang, learned senior G.A. appearing for the State as well as Mr. S. Rupachandra, learned ASG appearing for the Union of India.

Before we proceed further in the matter the order which was recorded on 02.12.2016 needs to be reproduced, which is hereunder.

“Mr. M. Rakesh, learned counsel appearing for the petitioner submits that under Janani-Sishu Suraksha Karyakram (JSK) both the pregnant women and also the women who deliver child as well as others covered under the scheme need not to bear expenses for diagnostics, medication, transportation etc. rather it is to be borne entirely by the State Government but the State Government has put cap over it by limiting the expenses to be borne by it which is as follows:

Smt. Chanem Mossang Vs. The State of A.P & Ors, WP(C). NO 307 AP (2016)

IN THE GAUHATI HIGH COURT
(HIGH COURT (OF ASSAM: NAGALAND: MIZORAM AND ARUNACHAL PRADESH)
ITANAGAR PERMANENT BENCH

Counsel for the Respondent GCA

IN THE MATTER OF:

Smti Chanem Mossang W/o Shri Thanro Mossang, resident of Village Nampuk, Changlang District, Arunachal Pradesh. ..-Petitioner

VERSUS

1. The State of Arunachal Pradesh represented by the Secretary/Commissioner Women & Child Development Department, Naharlagun, Arunachal Pradesh.
2. The Director, Women & Child Development | Department, Naharlagun, Arunachal Pradesh.
3. The Director of Health Service, Naharlagun, Govt of AP &. The Deputy Director, Women & Child Development Department, Changlang District, Arunachal Pradesh.

.. Respondents

at

WP(C) No. 307 (AP)/ 2016

BEFORE

HON'BLE MR. JUSTICE &.K.GOSWAMI

05-09-2016

Heard Mr. S. Mow, learned counsel for the petitioner. Also heard Mr. T. Tagum, learned Standing Counsel appearing for respondent No.3 and Ms. P, Pangu, learned State Counsel appearing for respondent Nos. 1,2 and 4. -

The petitioner delivered a baby girl on 24-09-2015 and she was registered under Primary Health

Centre, Kharsang for ante natal check under National Rural Health Mission. She submitted a representation to the respondent No.4 on 18-08- 2015 and another on 28-03-2016 for grant of Rs.10,000/- being maternity benefit to lactating mother. As the same are not acted upon, this writ petition is filed with a prayer for a direction to the respondents to pay the aforesaid amount.

The petitioner has also prayed for a writ of mandamus directing the respondent No.3 to pay Rs.700/- as cash assistance under the Janani Shishu Yojana (JSY) Scheme and also for reimbursing out of pocket expenses incurred under Janani Shishu Surakasha Karyakaram (JSSK).

Mr. Mow, very fairly, has submitted that no representation was earlier submitted to the respondent No.3, the . Director of Health' Services (DHS) for cash assistance and for reimbursement of out of pocket expenses.

Learned counsel for the respondents submits that the petitioner may file an appropriate representation before the Director of Health Services in connection with grant of cash assistance under the JSY Scheme and for reimbursement of out of pocket expenses under JSSK Scheme.

Upon hearing the learned counsel appearing for the parties and on consideration of the material on records, I dispose of the writ petition, without expressing any opinion on the merit of the case as presented by the wite petitioner, with the following directions:

- (1) The Child Development Project Officer, (CDPO), Changlang, will pass an appropriate order with regard to the representation dated 28-03-2016 (Annexure-B) regarding entitlement of the petitioner within a period of one month from the date of receipt of a certified copy of this order and if the petitioner is entitled to Rs.10,000/-, necessary steps will be taken by the respondents to pay her the amount within a period of 3 months; (2) the petitioner will be at liberty to file a representation before the Director of Health Services, Government of Arunachal Pradesh, Naharlagun, with regard to her claim for Rs.700/- under JSY Scheme and for reimbursement of out of pocket expenses under JSSK Scheme and in the event of filing any such representation, the same shall be considered within a period of 15 days from the date of receipt of the representation and thereafter, if the petitioner is found entitled to the amount, as claimed for, the same shall be paid within a period of one month.

The writ petition stands disposed of.

CERTIFIED TO BE A TRUE Copy

Moasenla vs State of Nagaland and Ors W.P (C) No. 252 (K) of 2018

Date of application for the copy.	Date fixed for notifying the requisite number for stamps and folios.	Date of delivery of requisite stamps and folios.	Date on which the copy was ready for delivery.	Date of making over to the applicant.
09-04-19	09-04-19	09-04-19	10-04-19	22.04.2019

IN THE GAUHATI HIGH COURT
(HIGH COURT OF ASSAM;NAGALAND;MIZORAM & ARUNACHAL PRADESH
KOHIMA BENCH

W.P.(C) NO.252(K) of 2018

Moasenla - Petitioner
Vs -
The State of Nagaland & 8 Ors. - Respondents

PRESENT
THE HON'BLE MR. JUSTICE MANISH CHOUDHURY

For the Petitioner : k.Kikhi
P.N. Phom
Pakimrichapbo
Neiteo Koza,Adv.
For the Respondent : Govt. Adv. Nagaland
N. Mozhu, Adv.
for R/Nos. 4 & 5.
Z.N. Ngullie, Adv. for R/No.9.

09.04.2019

ORDER

Heard Ms. Neiteo Koza, learned counsel for the petitioner.

Mr. L.L. Sangtam, learned counsel appearing on behalf of Mr. N. Mozhu, learned counsel for the respondent Nos. 4 & 5 prays for 3 (three) weeks' time to file affidavit-in-opposition.

Similar prayer is made by Mr. V. Zhimomi, learned Government Advocate for the respondent Nos. 1, 2, 3, 6, 7 & 8.

The prayer is allowed.

List the matter after **3 (three) weeks**.

Sd/- JUDGE

Certified to be true copy
20/04/19
Assistant Registrar (Jud.)
Gauhati High Court
Kohima Bench
Authorised U/S 76 ACT 1 of 1872



Rashmina Begum vs State of Nagaland and 8 Ors W.P (C) No. 203 (K) of 2018



THE GAUHATI HIGH COURT
(HIGH COURT OF ASSAM:NAGALAND:MIZORAM & ARUNACHAL PRADESH)
KOHIMA BENCH

W.P.(C) No. 203 (K)/ 2018

Rashmina Begum ... Petitioner
-vs-
The State of Nagaland & 8 Ors. ... Respondent

PRESENT
THE HON'BLE MR. JUSTICE N. KOTISWAR SINGH

For the Petitioner	:	K. Kikhi P.N. Phom, Advs.
For the Respondent	:	Govt. Adv. N/L N. Mozhui, SC. NHM For R/No. 4 & 5 C.G.C. For R/No. 9.

18-02-2019

ORDER

Heard Mr. Pankinrichapbo, learned counsel for the petitioner. Also heard Mr. V. Zhimomi, learned Govt. Advocate for respondent Nos. 1, 2, 3, 6 and 7 and Mr. N. Mozhui,, learned Standing counsel for respondent Nos. 4 and 5.

2. In this petition, the petitioner is claiming for release of the benefits, which she is entitled as a mother under the Janani Shishu Suraksha Krayakram (JSSK) and Jananai Suraksha Yojana (JSY) Schemes, under which pregnant women and children after delivery are entitled to certain benefits. Under the said Schemes, the Government of Nagaland also issued a notification on 14.05.2012, notifying the entitlements of the pregnant women and the sick new borns till 30 days after birth.

3. As regards entitlements of pregnant women, following entitlements have been listed.

1. Free and zero expense Delivery and Caesarean Section.
2. Free Essential Drugs and Consumables.
3. Free Essential Diagnostics.
4. Free Diet during stay in the health institution.



5. Free provision of safe blood (Wherever Blood Banks/Blood storage unit exist).
 6. Referral Transport Assistance from home to **nearest** health institution providing the relevant services.
 7. Referral Transport Assistance between facilities to nearest health institution providing the relevant service in case of referral.
 8. Referral Transport Assistance for Drop Back from health institution to Home after 48 hours stay.
 9. Exemption from all kinds of User Charges.
4. Further as regards, the sick new born till 30 (thirty) days after birth, the following entitlements have also listed.
1. Free and zero expenses treatment.
 2. Free Essential Drugs and Consumables.
 3. Free Essential Diagnostics.
 4. Free provision of safe blood (wherever Blood Banks/Blood storage unit exist)
 5. Referral Transport Assistance from home to nearest health institution providing the relevant services.
 6. Referral Transport Assistance between facilities to **nearest** health institution providing the relevant services in case of referral.
 7. Referral Transport Assistance to Drop Back from health institution to Home after 48 hours stay
 8. Exemption from all kinds of User Charges.
5. The petitioner had given birth to a child on 17.07.2018. In connection with the delivery of the child, the petitioner had incurred more than Rs.35,000/- (Rupees thirty five thousand only). In that connection, petitioner submitted a detail representation to the authorities claiming for grant of the aforesaid benefits under the said Scheme on 11.10.2018 as a reminder to the earlier representation dated 19.07.2018. In spite of her representations to the authorities as indicated above, there has been no response following which the petitioner has approached this Court by filing this petition.



6. This Court is of the view that if the authorities have implemented certain beneficial schemes for the mothers under Janani Shishu Suraksha Krayakram (JSSK)/Jananai Suraksha Yojana (JSY), there is no reason why they should not be given such benefits.
7. In that view of the matter, the present petition is disposed of with the direction to the respondent authorities, more particularly respondent Nos. 4, 5, 7 and 8, who are the authorities concerned with the implementation of the aforesaid scheme to examine the said claim of the petitioner for grant of Rs.35,000/- (Rupees thirty five thousand only) as mentioned in the representations and release the entitled amount to the petitioner without any further delay after making necessary verification, which exercise shall be undertaken by the respondent authorities within a period of 2 (two) months from today.
8. Copies of this order may be furnished to the learned counsel for the parties.

TRUE COPY


Administrative Officer (Judicial)
Gauhati High Court
Kohima Bench

SD/- JUDGE

• Implementation of Indian Public Health Standards

PAJHRA vs. State of Assam & Others, PIL 21/2012

PIL 21/2012

BEFORE

HON'BLE THE CHIEF JUSTICE MR. A.K. GOEL

HON'BLE MR. JUSTICE C.R. SARMA

(A.K. Goel, C.J.)

This petition seeks direction to implement National Rural Health Mission in the Tea Estates, inter alia, by providing access to safe abortion services, timely and adequate referral system, access to a functioning blood bank, appointing sufficient number of Doctors and supporting staff at all levels, establishment of better transport system, conduct audit and quality control review of the health services, to review and monitor implementation and delivery of health services with monitoring mechanism through vigilance committees and civil societies and to collect relevant data.

The petitioner claims to have made a representation (Annexure-2 to the petition) to the Additional Chief Secretary, Health and Family Welfare Department, Government of Assam, raising question about non-implementation of health schemes in Sonitpur District.

Undoubtedly, National Rural Health Mission is a programme introduced by the Government of Assam to provide health care to benefit the rural population.

The fact remains that the implementation has to be done by the concerned authorities in the Government.

Only direction that can be issued at this stage is to look into the representation of the petitioner in accordance with law. Let this be done. We hope and trust that the concerned authorities will perform their duty sincerely in implementing the scheme which provides for access to basic health services for most disadvantaged sections of the society.

The petition stands disposed of accordingly.

Geeta Postsang Vs. State of Manipur & 3 Ors, PIL NO 21 OF 2016

IN THE HIGH COURT OF MANIPURAT IMPHAL

PIL NO. 21 OF 2016

With

(PIL No. 5/2017 with PIL No. 12/2017 with PIL No. 18/2016 with PIL No. 23/2016 with PIL No. 25/2016 with PIL No. 26/2015 with PIL No. 27/2016 with PIL No. 29/2016 with PIL No. 30/2015 with PIL No. 31/2015 with PIL No. 36/2016 with PIL No. 38/2015 with PIL No. 38/2016 with PIL No. 39/2015 with PIL No. 40/2015 with PIL No. 41/2015 with PIL No. 42/2015 with PIL No. 43/2015 with PIL No. 44/2015 with PIL No. 51/2015 with PIL No. 52/2015)

Geeta Potsangbam

... Petitioner.

Versus

State of Manipur & 3 others

... Respondents.

B E F O R E

THE HON'BLE THE ACTING CHIEF JUSTICE N. KOTISWAR SINGH

THE HON'BLE MR. JUSTICE KH. NOBIN SINGH

For the petitioner Mr. M. Rakesh, Advocate

For the Respondents A.G. Manipur,
R. S. Rupachandra, ASG
R. Viscount, Advocate

Date of order 31-07-2017

O R D E R

Today, as many as 22 PILs have been taken up highlighting the various alleged deficiencies either by way of lack of proper of infrastructure or man-power in various Public Health Centres/Sub-Centres/ Primary Health Centres and Community Health Centres located in various parts of the State.

Since the State Government has not admitted to these deficiencies which have been highlighted in these PILs, we are of the view that samples survey of the functioning of these Public Health Centres/ Sub-Centres/Primary Health Centres and Community Health Centres may help in deciding the issues raised in the these PILs.

Accordingly, having obtained consent from the learned members of the Bar, a Committee of lawyers will be formed who will visit the various Centres/Sub-Centres located in all the District and submit a report before this Court by examining the issues. For this the following members of the Bar are appointed as proposed, for visiting the respective areas as mentioned below.

1. UKHRUL AND KAMJONG DISTRICTS.
 - I) Mr. Mark Khapai (Advocate)
 - II) Mr. Aaron Keishing (Advocate)
 - III) Mr. PhokmiRephung (Advocate)
2. CHANDEL AND TENGNUUPAL DISTRICTS.
 - I) Mr. Rebirthson (Advocate)
 - II) Mr. SaimondLanghu (Advocate)
3. TAMENGLONG AND NONEY DISTRICTS.
 - I) Mr. Ag. Chingkhiugong (Advocate)
 - II) Mr. Julius Riamei (Advocate)
 - III) Mr. K.R Pamei (Advocate)
4. CHURACHANDPUR AND PHERZAWAL DISTRICTS.
 - I) Mr. B.R. Sharma (Advocate)
 - II) Ms. Joan Kipgen (Advocate)
5. SENAPATI AND KANGPOKPI DISTRICTS.
 - I) Mr. Adani Kamuo Mao (Advocate)
 - II) Mr. R.S. Livingstone (Advocate)
 - III) Mr. KamminthangKhongsai (Advocate)
6. IMPHAL EAST, IMPHAL WEST, THOUBAL AND BISHNUPUR DISTRICTS
 - I) Mr. N. Jotendro (learned senior counsel)
 - II) Mr. M. Rarry (Advocate)

The Committee may decide the Public Health Centres/Sub-Centres/Primary Health Centres and Community Health Centres to be visited and the Committee may submit the report by 30th August, 2017 after visiting these.

In this regard, we call upon the State Government to pay a sum of Rs. 5000/- each to the learned members of the Committee as a token honourarium. The respective District authorities are directed to co-operate with the visit of the members of the Committee which may be intimated to the District authorities in advance so that the District authorities may render all necessary help to the visiting learned Committee.

Copies of this order may be furnished to Commissioner/Secretary (Health), Director of Health & Medical Officers/Chief Medical Officers of all the districts for necessary assistance and co-operation for the visit by the Committee members. The concerned district DMOs/CMOs may also arrange conveyance for the visit of the members of the Committee to the Centres/Sub-Centres.

Copies of this order may also be furnished to all the counsel for the parties as well as their members of the Committee.

The report, if possible be submitted along with the photographs of the conditions of the said Centres.

List the matter again on 30th August, 2017.

SD/- KH. NOBIN SINGH
SD/- N. KOTISWAR SINGH

JUDGE
ACTING CHIEF JUSTICE

Dusa Yama vs. State of A.P and 3 Ors. PIL 06 AP (2016)

IN THE GAUHATI HIGH COURT

(HIGH COURT OF ASSAM: NAGALAND: MIZORAM AND ARUNACHAL PRADESH)

ITANAGAR PERMANENT BENCH Appeal From

Writ Petition (Civil)

Appellant

Petitioner.

Versus

Respondent” the AP & ess

Opposite Party.

Counsel for the Appellant C Mae Petitioner.

Counsel for the Respondent Opposite Party.

07-07-2017

- i) The honourable Court gave discretion that the Departmental Commissioner may constitute a team of competent Health Officials from the Health Department of State:
- ii) The aforesaid team may conduct physical administration of all the District Hospitals, PHCs and CHCs and thereafter, submit a fact finding report to the Government indicating the present status of the amenities and basic facilities available therein.
- iii) Based on such report, The Govt. would initiate proper action so as to ensure that adequate medical & healthcare facilities are made available in all the District Hospitals, CHCs PHCs within the State.

The exercise is directed by the Court to be carried out within a period of six months from the date of receipt from the copy of the order.

A copy of the fact finding report so prepared be furnished, free of cost, to the petitioners if an application is made by them, to that effect.

Considering the seriousness of the issues involved in these proceeding, this Court expect that the State Govt. will treat the matter with utmost seriousness and with top priority.

With the above observations, this writ petition stands disposed off.

Alin Mahanta vs. State of Assam & Ors, PIL NO 118 of 2015

BEFORE

HON'BLE THE CHIEF JUSTICE MR. AJIT SINGH

HON'BLE MR. JUSTICE MANOJIT BHUYAN

20.07.2017

(Ajit Singh, CJ)

Ms. N Deka, learned counsel for the petitioner.

Mr. D Saikia, learned Senior Additional Advocate General, Assam, assisted by Mr. B Gogoi, learned Standing Counsel, Health and Mr.S Sarma, learned Senior Central Government Standing Counsel.

This Public Interest Litigation has been filed by the petitioner-Miss Alin Mahanta-stating inter alia that Kanaklata Civil Hospital, situated at Sonitpur District of Assam has no basic infrastructure to provide adequate treatment to the patients. A fact-finding team consisting of social activists and lawyers conducted a survey in the said hospital on 01/03/2015 and found that pregnant women, who came for delivery, were lying in the floors of the hospital due to shortage of beds. The said hospital is a 200 bedded hospital, but considering the frequency of the patients, the same is too meager and there was no move from the state government to augment the same. Only 35 beds were allotted to the maternity ward although it should have been 50. Besides, other facilities such as ambulance, staff nurses, gynecologists, radiologists, surgeons, pediatrician etc. are not adequate. It has also been contended that the rate of deliveries carried out in the said hospital in a day is much higher than what the hospital could accommodate. According to the Indian Primary Health Standard (IPHS, in short hereinafter) the hospital should not have cracked walls, those should be free from seepage, there must not be any broken window, pans etc., but the said standards are not seen to have been maintained in the said hospital. Besides, there is no Intensive Care Unit (ICU) in the hospital and only 5(five) beds are there in the labor room, which is inadequate. Therefore, appropriate natal and post-natal facilities are lacking in the said hospital causing infringement of

the Fundamental Rights of the people at large especially the women from the lower strata of the society as guaranteed under Article 21 of the Constitution of India, and hence it has been prayed that manpower in the said hospital may be enhanced as well as facilities may be provided as per the IPHS guidelines, ambulance services may be increased and a review of the maternal deaths in the district may be conducted.

The respondent no.2-Commissioner and Secretary to the Government of Assam, Department of Health and Family Welfare, has filed affidavit-in-opposition stating that various government schemes for family planning and benefiting the mothers and their babies have been widely implemented in the said hospital without any discrimination, whatsoever. It has also been stated that the government has enacted the Assam public Health Act, 2010 to provide for protection and fulfillment of rights in relation to health and well-being of the public at large and as such every endeavor has been made to safeguard the interest of the people. It has been stoutly denied that proper hygiene is not maintained in the said hospital and on the contrary, it has been stated that regular treatments are being rendered to both the indoor and outdoor patients and surgeries, too, are being carried out successfully. Considering the rush of people, the numbers of beds have been increased to 263 from the earlier 200 beds, out of which, 81 beds have been exclusively allotted to the Obstetrics and Gynecology Ward. Repair and renovation works have very recently been carried out and the IPHS Guidelines have been strictly adhered to, in the said hospital. Besides, the number of nurses allotted duty in the Obstetrics and Gynecology Ward are also apportioned as per the said

Guidelines. Further, the ambulance services are provided for transporting pregnant women by means of 108 and 102 ambulance services and they are also transported to their respective homes after delivery by 'Adarani' ambulances. Besides, there is facility for round the clock institutional delivery and other allied services.

The petitioner has stated in the affidavit-in-reply that during a subsequent visit by a team on 04/09/2016 it was found that the maternity ward was too crowded and there was shortage of beds and there was shortage of other medical facilities too. However, it has not been denied that the numbers of beds have been increased, facilities under various Government Schemes have been implemented, cash delivery assistance has been provided to the mothers etc.

Upon hearing the learned counsel for the parties and upon perusal of the records, we are of the view that the Government has been making reasonable and sufficient endeavor to provide the basic facilities to the needy. Various welfare schemes especially for the welfare of the pregnant women have been implemented as far as possible. They have been provided with ambulance facilities whenever needed and have been also provided with cash delivery assistance. Further, the repair and renovation works also reported to have been done in the hospital recently. However, the authorities are required to review the same regularly so that proper hygiene is maintained. No doubt, with the increase of population in the nearby area and patients frequenting the hospital, the beds and other facilities are bound to be increased. We hope and expect that the respondent authorities shall make every endeavor to increase the same adequately.

The respondent authorities have stated that the IPHS Guidelines have been strictly adhered to in the said hospital and the State Government will soon be appointing Radiologist, Dermatologist and Orthopedic Surgeon in the hospital. The authorities are, therefore, directed to monitor/review the same periodically and adhere to the IPHS Guidelines strictly for providing better facility to the poor and needy. We also direct the State Government to appoint Radiologist, Dermatologist and Orthopedic Surgeon in the hospital within 45 (forty five) days from today.

With the above observations, the instant Public Interest Litigation is disposed of.

The Registry shall supply a copy of this order to Sri D. Saikia, Senior Additional Advocate General, Assam, for information and compliance. No order as to costs.

JUDGE

CHIEF JUSTICE

Alin Mahanta vs. State of Assam & Ors, PIL NO 12 of 2015

GAHC010228002016

THE GAUHATI HIGH COURT
(HIGH COURT OF ASSAM, NAGALAND,
MIZORAM AND ARUNACHAL PRADESH)

Case No. : PIL 12/2016

1:ALIN MAHANTA

D/O. LT. NISHI KT. MAHANTA, HOUSE NO.13, LAMB ROAD, UZANBAZAR, GHY.,
DIST. KAMRUP M, PIN-781001, ASSAM.

VERSUS

1:THE STATE OF ASSAM AND 5 ORS

REP. BY CHIEF SECY., DISPUR, GHY., ASSAM.

Advocate for the Petitioner: MR.A DHAR

Advocate for the Respondent : SC, BTC

20.05.2019:

(A. S. Bopanna, CJ)

BEFORE

HON'BLE THE CHIEF JUSTICE MR. A. S. BOPANNA HON'BLE MR. JUSTICE ARUP
KUMAR GOSWAMI

O R D E R

Heard Ms. D. Ghosh, learned counsel for the petitioner. Also heard Mr. D. Saikia, learned senior counsel assisted by Ms. A. Das, learned counsel for respondent No.1 to 4; Mr. A. Talukdar, learned Standing Counsel, BTC for respondent No.5 and Mr. S. Sarma, learned senior Central Government Counsel for respondent No.6.

The petitioner is before this Court in this petition filed in public interest raising a grievance that the Government Hospitals in Baksa district do not possess the services of Blood Bank. In that light it is contended that the same had led to other situations which had resulted in the post-delivery deaths.

During the pendency of the instant petition, the matter has been pursued by the Government and steps have been taken to establish a Blood Bank.

When the matter is taken up for consideration today, the learned senior counsel representing the State respondents has made available to this Court a copy of the licence issued by the Central Licensing Approving Authority to the Drugs Controller, Assam permitting to operate the blood bank for collection, storage and processing. Since at an earlier point it had been brought on record that Blood Bank had been established and the functioning of the same was awaited subject to issuance of licence, presently the entire process has been completed and the Blood Bank would be operational.

In that view, the main grievance as raised in the instant petition has been answered and in so far as the other issues raised in the instant petition, they are ancillary to the fact that the Blood Bank has not been established. However, since at present the Blood Bank has been established, it would not be proper for us to go into the other aspects of the matter. However, if any other issue is subsequently raised, liberty is reserved to the petitioner and to any other litigants to approach this Court.

In terms of the above, the petition stands disposed of.

JUDGE

CHIEF JUSTICE

Comparing Assistant

Hillson Angam vs. State of Manipur and ORS W.P No. 10/2018

IN THE HIGH COURT OF MANIPUR
AT IMPHAL

PIL NO. 10 OF 2018



Mr. J. Hillson Angam

... Petitioner

-vs-

State of Manipur & 4 ors.

... Respondents

BEFORE

HON'BLE THE CHIEF JUSTICE MR. RAMALINGAM SUDHAKAR
HON'BLE MR. JUSTICE KH. NOBIN SINGH

For the petitioner : Mr. M. Rakesh, Id. Advocate.

For the respondents : Mr. N. Kumarjit, Id. A.G.

Date of order : 12-7-2018.

ORDER

R.S. C.J.,

This Public Interest Litigation is filed on the issue relating to establishment of Blood Banks in all the District Hospitals, Community Health Centres and Primary Health Centres and Primary Health Sub-Centres along with Blood Bank or Blood Storage Units in the District Hospitals in the State of Manipur.

The petitioner highlighted the condition of the present Blood Banks stating that it is in a very dismal condition and not being properly maintained and further goes on to plead that the Blood Banks have not been established in many of the District Hospitals and Community Health Centres and Primary Health Centres etc.

There is a response filed by the first and second respondents and the learned Advocate General states that steps have been taken to establish new Blood Banks.

Considering the serious issue namely maintenance of proper Blood Bank for the benefit of victims, who may need emergency blood and to ensure

the Blood Banks and the Blood Storage Units are properly maintained in hygienic condition, the Court is inclined to appoint the following Advocates:

1. Ksh. Harichhaya, Advocate,
Mobile No.8132919490,
2. Laisom Sillori, Advocate,
Mobile No.9612696142,
3. N. Savitri Devi, Advocate,
Mobile No.8994567725/8794567725
4. Henba Thokchom, Advocate,
Mobile No.9742590679,
5. Th. Rohitkumar Singh, Advocate,
Mobile No.9774671078.



The Advocate Commissioners have to inspect the various Blood Banks and report to this Court as to the condition of the Blood Banks and the manner in which they are maintained. The Director, Health Services, Manipur will depute a senior officer to go along with the Advocate Commissioners to inspect the Blood Banks and the Advocate Commissioners shall file a report after completion of the inspection with all the shortfalls or errors in maintenance of Blood Banks.

Each Advocate Commissioners will be paid a sum of Rs.5000/- as remuneration by the State Health Services Department with proof to be submitted before this Court.

List the matter after filing of the report of the Advocate Commissioners on 20-08-2018.

All assistance to be given by the Health Department to the Advocate Commissioners without any demur.

Copy of this order be furnished to the learned A.G. and counsel for the petitioner and Advocate Commissioners.

Sd/- KH. NOBIN SINGH
JUDGE

Sd/- RAMALINGAM SUDHAKAR
CHIEF JUSTICE

True Copy :

Reeta Laishram
(REETA LAISHRAM) 20/8/2018
Supdt. Judt-III

Compared by : *H. Herojeet Singh.*

Supdt. Judt-III
High Court of Manipur
Imphal (Manipur)

No.HCM/PIL/10/2018/16794-800

Date : 20-7-2018

Copy to :

1. Mr. N. Kumarjit, Id. A.G.
 2. Mr. M. Rakesh, Id. Advocate.
 3. Ms. Ksh. Harichhaya, Advocate.
 4. Ms. Laisom Sillori, Advocate.
 5. Ms. N. Savitri Devi, Advocate.
 6. Mr. Henba Thokchom, Advocate.
 7. Mr. Th. Rohitkumar Singh, Advocate.
- ... for information & necessary action.



M.C. Nandini 20/7/18
ASSISTANT REGISTRAR-I

Assistant Registrar-I
High Court of Manipur
Imphal

Medical Negligence

Madhav Lal vs. State of Madhya Pradesh W.P No. 3071/2017

THE HIGH COURT OF MADHYA PRADESH WP-3071-2017
(MADHAVLAL Vs THE STATE OF MADHYA PRADESH)

Gwalior, Dated : 13-12-2017

Shri Amin Khan, learned counsel for the petitioner. Shri Raghvendra Dixit, learned Government Advocate for the respondents/State.

Shri A.R. Mander, learned counsel for the respondent No. 11.

Let this matter be listed on 8th January, 2018 to enable respondent No. 11 to file reply and the petitioner to file rejoinder to the reply filed by other respondents, failing which, right to file rejoinder shall stand closed.

As prayed, list this matter in the week commencing
8th January, 2018.

Learned Government Advocate for the State is directed to make his submission as to whether cost imposed by this Court vide order dated 29/08/2017 has been deposited by the Officer-in-Charge of the case in the "*High Court of Madhya Pradesh Middle Income Group Legal Aid Society*" or not?

(SANJAY YADAV) JUDGE

(SUNIL KUMAR AWASTHI) JUDGE

Shanti Devi and Anr. V. Safdarjung Hospital and Ors. W.P(C) 9499/2017

§-14

*IN THE HIGH COURT OF DELHI AT NEW DELHI
+ W.P.(C) 9499/2017

SHANTI DEVI & ANR

..... Petitioners

Through: Ms Sija Nair Pal and Mr Deepak
Kumar Singh, Advocates.

versus

SAFDARJUNG HOSPITAL AND ORS

..... Respondents

Through: Ms Monika Arora, CGSC with Mr Harsh Ahuja, Mr Kushal Kumar and Mr Vibhu Tripathi, Advocates for UOI.

CORAM:

HON'BLE MR. JUSTICE VIBHU BAKHRU

O R D E R

% 03.01.2018

1. The learned counsel appearing for respondent no.1 submitted a report indicating that there was no medical negligence, as “no resuscitation was required in this case as the abortus was not compatible with any survival”.
2. The learned counsel appearing for the petitioners points out that the facts of this case are

almost similar to the recent case of MAX Hospital, which was shut down by the concerned authorities as the hospital had returned baby/fetus declaring him/her to be dead, although, it later transpired that the fetus had some life. The learned counsel for the petitioners insists that the infant in that case was also delivered prematurely (approximately after five months of gestation period). In these circumstances, respondent no.2 is directed to produce the necessary records of the said case.

3. Clearly, the respondents cannot have two standards for medical treatment one for private hospital and the other for government hospital.
4. It was also noticed in the last order that the photographs annexed with the petition, which showed the manner in which the infant was handed over to his father were disturbing. At that stage, this Court had refrained from making any adverse observation in this regard considering that the directions were issued for constitution of a Committee to examine the matter. It is seen that the report submitted by the Committee does not consider the manner in which the fetus was handed over by the concerned authority.
5. It is not possible for this Court, after having viewed the photographs, to ignore the same. Respondent no.1 shall file an affidavit indicating as to the person responsible for handing over the fetus in the manner it was done and further indicating whether any steps are proposed to be taken in this regard.
6. It is noticed that on the last date of hearing i.e. 02.11.2017, the Medical Superintendent of respondent no.1 was directed to ensure that the copy of medical records available with respondent no.1 be provided to the petitioner. The learned counsel for the petitioner states that the same has not been handed over. A final opportunity is granted to the concerned Medical Superintendent to do so within a period of one week from today. He is further cautioned that this Court will take a serious view if orders of the Court are not complied with.
7. List on 18.01.2018 for further proceedings.

VIBHU BAKHRU, J

JANUARY 03, 2018

Shanti Devi and Anr. V. Safdarjung Hospital and Ors. W.P(C) 9499/2017

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* IN THE HIGH COURT OF DELHI AT NEW DELHI
+W.P.(C) 9499/2017

SHANTI DEVI & ANR

Petitioners

Through: Ms Sija Nair Pal, Advocate. versus

SAFDARJUNG HOSPITAL AND ORS

Respondents

Through: Mr Sanjoy Ghose, Advocate for GNCTD.

CORAM:

HON'BLE MR. JUSTICE VIBHU BAKHRU O R D E R

% 26.11.2018

1. The petitioners have filed the present petition, inter alia, praying as under:-
 - a. Issue a writ of Mandamus or any other appropriate writ order or direction to the Respondents to constitute a independent committee to review the incident of gross medical negligence and address these shortcomings so that poor and impoverished women receive respectful and dignified care and the life of the infant and the mother is not put at risk.
 - b. Pass an order directing the Respondent No.1 to compensate the Petitioners & their family for the expenses incurred by them and the mental & financial trauma that they had to bear due to the gross medical negligence caused by the respondent No.1.
 - c. Pass an order directing the Respondent No.1 to provide the Petitioners with copies of all the medical documents of the deceased infant including head ticket, death certificates etc. issue by them but not released to the petitioners till date.
 - d. pass an order directing the Respondent No.4 to provide copies of documents received by him from Respondent No.1 hospital with respect to petitioner No.1 & the deceased infant

to the Petitioners and also to report to this Hon ble Court the status of the complaint lodged by the Petitioners against the Respondent No.1 Hospital.

- e. Issue a writ of Mandamus or any other appropriate writ order directing Respondent No.2 to initiate an independent enquiry & to take appropriate action against the respective medical staff of the Respondent No.1 Hospital who declared the live infant to be dead at the first instance & deprived the deceased infant of his feeble chance of survival.”
2. Petitioner no.1 was admitted with respondent no.1 hospital on 15.06.2017 and delivered a premature fetus on 18.06.2017. The infant was born in the fifth month of the pregnancy. The fetus was declared dead and the body was handed over to petitioner no.1.
3. Petitioner no.2 (father) of the infant took home for last rites. However, found that the infant was still gasping for air. The infant was immediately bought back to respondent no.1 hospital and was put on oxygen. It is the petitioner s case that the infant, survives for 36 hours thereafter and finally expired on 4:15 PM on June 19, 2017.
4. Insofar as the petitioners prayer for seeking medical records is concerned, this Court by an order dated 02.11.2017 had directed that the same be handed over to the petitioners. Admittedly, the petitioners have received the records and the petitioner s grievance in this regard stands satisfied.
5. This Court had also directed that an independent enquiry be conducted with regard to the allegations made in the present petition. Pursuant to the aforesaid orders, a Committee was constituted by three senior officers (Dr A. K. Gadpayle, Addl. DGHS, Dte. GHS; Smt. Gayatri Mishra, Joint Secretary (Hospital), Ministry of Home and Family Welfare; and Dr V. K. Tiwari, Medical Superintendent, Dr RML Hospital, New Delhi). The said Committee also invited four other doctors as special invitees. The Committee examined the records as provided by respondent no.1 hospital. A copy of the report has been handed over to this Court.
6. The same, inter alia, indicates as under:-
 - “8. During conservative management, patient aborted a conceptus of 470 gms on 18.06.2017 spontaneously.
 9. Abortion is the expulsion or extraction from its mother of an embryo or fetus weighing 500 gms. or less when it is not capable of independent survival (WHO). The expelled embryo or fetus is called abortus. (Annexure II). The abortus was observed for 60 mins. (which is median survival rate for abortus below 20-22 Wks.) (Annexure VII) and handed over to relatives for last rites as there were no signs of life observed during this period.”
7. The Committee also concluded as under:- **“Conclusion:**
 1. Technically by virtue of gestational age and weight the outcome of pregnancy in this case qualifies to be an abortus and not a "baby" and did not merit proactive resuscitation
 2. Resurgences of some signs of terminal gasps/flickers of movement in such an abortus on

receiving some warmth is known as per expert opinion.

3. By all international/international standards no resuscitation was required in this case as the abortus at this age is not compatible with any survival.
 4. Thus considering all the above points, there does not appear to be any medical negligence on the part of treating doctors and standard management guidelines have been followed.”
8. It is relevant to note that the Committee also made certain recommendations, which are set out below:-

“Recommendations:

1. There should have been more open and transparent communication with the patient about the prognosis of abortus.
2. The committee appreciates the concerns and anxiety of the parents in such cases and recommends that the treating doctors should empathize with such parents and family members.
3. In doubtful cases opinion of experts should be taken, the parents should be kept informed about decision making and abortus should be handed over to the parents after complete satisfaction of the parents regarding cessation of life.”
9. The learned counsel appearing for the petitioner states that there are certain factual discrepancies as according to the petitioner the infant did survive for 36 hours. The learned counsel appearing for the petitioner also relies on the Death Summary furnished to the petitioner, in support of the aforesaid claim.
10. This Court is of the view that since the controversy in this regard involves disputed question of facts, it would not be apposite to examine the same in this petition.
11. In view of the above, the present petition is disposed of leaving it open for the petitioners to institute an appropriate action for compensation, if so advised.

VIBHU BAKHRU, J

NOVEMBER 26, 2018 MK

Snehalata “Salenta” Singh v. State of Uttar Pradesh, High Court of Allahabad W.P. 14588/2009

HIGH COURT OF JUDICATURE AT ALLAHABAD

(AFR)

Reserved on : 21.12.2017

Delivered on : 09.03.2018

Court No. - 34

Case :- PUBLIC INTEREST LITIGATION (PIL) No. - 14588 of 2009

Petitioner :- Snehalata Singh @ Salenta And Others

Respondent :- State Of U.P. And Others

Counsel for Petitioner :- Prem Prakash Singh, K.K. Roy, Namrata Singh

Counsel for Respondent :- C.S.C., Additional Solicitor General of India, Dr. A.K. Nigam, S.S. Tiwari

with

Case :- PUBLIC INTEREST LITIGATION (PIL) No. - 65217 of 2008

Petitioner :- Raj Kumar Singh

Respondent :- State Of U.P. through Secretary Health And Others

Counsel for Petitioner :- P.K.S. Paliwal, D.V. Singh, Jameel Ahmad Azmi, S.N. Singh

Counsel for Respondent :- C.S.C.

Hon'ble Sudhir Agarwal, J.

Hon'ble Ajit Kumar, J.

(Delivered by Hon'ble Sudhir Agarwal, J.)

1. The writ petition No. 14588 of 2009 (hereinafter referred to as “First Petition”) under Article 226 of the Constitution of India, has been filed as a Public Interest Litigation, highlighting

pathetic conditions of medical services in State of U.P., with special reference to personal experience of petitioner-1, a working woman labour getting a traumatic handling of maternity services in the hospitals maintained by State of U.P. including hospitals of Medical Colleges and Medical University.

2. Petitioner-2, a Non-Government Organization (hereinafter referred to as “NGO”) is registered as a Society under the provisions of Society Registration Act, 1860 (hereinafter referred to as “Act, 1860”), working in the State of U.P. and Uttaranchal, for welfare of women and children and their health. Similarly, petitioner-3 is a network of various organizations taking care of health conditions and medical services in State of U.P., though an unregistered body.
3. Illustrative case brought forth before Court is that petitioner-1, Sneh Lata Singh w/o Kamal Singh, felt labour pain on 13.02.2007 and at 5 AM was taken to Purkaji Public Health Centre (hereinafter referred to as “Purkaji PHC”), a Village Panchayat Level Medical Health Care Centre established and maintained by State Government. She went on the advice of Ms. Geeta Sharma, Auxiliary Nurse Midwife (for short “ANM”) who told petitioner-1 to go for treatment at Government Medical Health Care Centre where she would get an incentive of Rs.1400/- under Janani Suraksha Yojna (hereinafter referred to as “JSY”), a Scheme launched by Central Government with an objective to encourage Institutional delivery. The aforesaid ANM at Purkaji PHC asked petitioner-1’s husband Kamal Singh to buy an injection and glucose bottle, which he bought. Thereafter glucose was administered to petitioner-1. At 10 AM she gave birth to a baby girl. No other person except the aforesaid ANM was present in Purkaji PHC on the said fateful day i.e. 13.02.2007. Ms. Geeta Sharma, ANM, demanded Rs.450/- for getting delivery performed at Purkaji PHC. Though demand was apparently illegal but petitioner-1’s husband went to Sri Shakarpur Medha, owner of brick kiln, where he was working, borrowed Rs.250/- and gave that money to Ms. Geeta Singh (ANM). Only thereafter petitioner-1 was discharged by the aforesaid ANM.
4. While returning home, petitioner-1 realized continuous discharge of urine. She was surprised since it was her sixth delivery and in past she never had such complication. Urine discharge continued, whereupon petitioner-1 visited Purkaji PHC on 17.02.2007 accompanied by her husband, and met Dr. J.P. Tyagi. He told that continuous discharge of urine is not a big problem. He advised some medicines, stating that it will give relief. However, problem of continuous urine discharge persisted. Petitioner-1 and her husband again went to Purkaji PHC. This time they met Doctor J.P. Tyagi and Ms. Geeta Sharma. Another Doctor Ojha was also present. He advised petitioner-1 some other medicines and assured that this time she would have relief. Dr. Tyagi and Dr. Ojha simultaneously told petitioner-1 and her husband that treatment in Purkaji PHC would be same and it is advisable to go to some private hospital for treatment. Since problem continued, Petitioner-1 along with her husband went to Laksar Hospital in District Haridwar. There she was admitted for six days and treated for infection with antibiotic medicines. Hospital’s prescription dated 10.03.2007 is on record and refers to following medicines:

“Injection Gentamicin 80 ml	(6)
Tablet Loxof 500mg x 2	(4)
Tablet Ramisper x 2	(4)
Tablet Dipsodiag, one at night	(2)
Food use in liquid	
Tab. Lasilactone	(½ in morning)”

5. Petitioner-1’s problem still persisted. Thereupon her husband brought her to a Private Hospital namely Agarwal Medical Centre, (Pappu Nursing Home), Laksar District-Haridwar. Here she remained admitted for 3 days and administered with antibiotics. Finding no respite, she was taken by her husband to another hospital, namely, Mother and Child Hospital and Laparoscopic Centre, Ram Nagar, Roorkee where she was attended by Dr. Smt. Anshu Agarwal, an Obstetrician, Gynecologist and Laparoscopic Surgeon. She administered some treatment and also got few tests conducted but could not diagnose reason for persistence of urine discharge. Petitioner-1 was advised to go Jolly Grant Hospital, Haridwar but due to financial constraints petitioner and her husband returned to their home. Discharge of urine continued hence on 25.05.2007 petitioner-1 was taken to S.D. Medical Institute and Research Centre, Muzaffarnagar where it was detected that she had Urethra-Vaginal Fistula, a hole in the bladder. For this testing, she paid Rs.300/-. Since she lacked sufficient means for further treatment hence Hospital did not provide further treatment. On 26.05.2007 she visited Ravi Nursing Home, Sadar Bazar, Muzzafarnagar where certain medicines were prescribed. This prescription is on record as Annexure-4 to writ petition and refers to following medicines:

“Plenty of fluids orally.

Tab. Levown 500 mg.

Tab. Aciloc Cap. Rinifol Tab. Deneveron Tab. Urikind Syp. Alkasol”

6. Petitioner-1 managed intake of medicines for about 15 days but same being very expensive, had to be discontinued for paucity of funds.
7. On 15.06.2007 petitioner-1 knocked the door of District Magistrate, Muzaffarnagar who advised to contact Chief Medical Officer (hereinafter referred to as “CMO”), Muzaffarnagar. Petitioner-1 met CMO, Muzaffarnagar who forwarded her to Chief Medical Superintendent, Lala Lajpat Rai Medical College, Meerut (hereinafter referred to as “LMC”), a State Medical College maintained by State of U.P. (hereinafter referred to “SMC, Meerut”), along with letter dated 15.06.2007. Since petitioner was not attended by Government Medical Officer at Muzaffarnagar and sent to Meerut, she tried to meet other Medical Officers at Muzaffarnagar and in this process met Deputy Chief Medical Officer who behaved very arrogantly and told petitioner-1 that she would not get any medicine or proper treatment since she had complained

the matter to higher authorities. He also required petitioner-1 to give in writing that she did not go for Institutional delivery.

8. Later on, with the letter dated 15.06.2007 given by CMO, Muzaffarnagar, petitioner went to SMC, Meerut where she was called for operation on 16.07.2007 and sent home. On 16.07.2007 when petitioner-1 and her husband visited SMC, Meerut, they did not find anyone to attend her. They stayed at a hotel and again went to SMC, Meerut where a Journalists from a news channel "Aaj Tak" met her. She explained her plight to the said Journalist, who contacted officials at SMC, Meerut, whereupon a Senior Medical Officer gave another date for operation i.e. 24.07.2007.
9. On 19.07.2007, petitioner-1 learnt that a meeting of National Rural Health Mission (hereinafter referred to as "NRHM") was going on and an Organization namely "Astitva Samajik Sanstha" was also present thereat. Petitioner-1 approached aforesaid Sanstha and explained her miseries. She was then sent to Women Hospital, Muzaffarnagar. On 24.07.2007, petitioner-1 went to SMC, Meerut for operation but told by a Junior Doctor that she would have to pay Rs.20,000/- for the said operation. Having no money with her, she had no option but forced to return back to home. In the meantime, petitioner-1 continued to intake medicines as advised at Women District Hospital, Muzaffarnagar.
10. Petitioner-1 learnt about a meeting of officials of petitioner-3 and Government on 01.08.2007 at Lucknow. She came to the meeting and presented her case before officials of petitioner-3. Thereafter print media carried her story and details of prolonged and pathetic treatment in the hands of Medical Officers at different level in the State and quest for justice. On 28.09.2007 petitioner-3, "Health Watch Forum" and another NGO "Humsafar" took petitioners-1 to "King George Medical College, Lucknow", later termed as "King George Medical University", Lucknow (hereinafter referred to as "KGMU"), where she was examined and diagnosed to have 'Fistula'. She also underwent certain tests but was told that presently no bed is vacant and whenever it is available, she would be informed and called for operation. Thereafter on 25th and 26th October, 2007, petitioner-1 went through several tests in KGMU, but operation was not performed for want of bed. She was informed by "Health Watch Forum" and "Hamsaffar" that doctors at KGMU have fixed a date for operation sometimes in January, 2008. Thereupon she went to KGMU and again got tested as per advice of Doctors but could not be operated since bed was not available.
11. On 04.02.2008 a test, namely, Perabdominal Urosonography in the Department of Urology was conducted. Thereafter petitioner-1 was operated on 05.02.2008 at KGMU. She was discharged on 22.02.2008 and returned to Muzaffarnagar. She went to KGMU on 11.03.2008 for removal of Catheters but same could not be removed. Even this removal of Catheters took more than 1 and 1/2 months and could be removed only on 25.04.2008 when petitioner-1 visited again KGMU.
12. It is further said that Ministry of Health and Family Welfare, Government of India, in its

guidelines issued for NRHM has given details of vision of the Mission, Objectives, Expected Functioning, Community Level, Core Strategies of Mission, Supplementary Strategies of Mission, Special Focus and also details of the work already undergoing for implementation of Mission. Institutional framework has been detailed in para 5 under the heading “The Efforts So Far” whereunder details of Programmes, Infrastructure, District Plans, Procurement, Technical Support to the Mission, Training and Capacity Building have been mentioned. The same read as under:

“ 5. The emphasis in the first six months since the launch of the mission has been on the preparatory activities necessary for laying the ground work for implementation of the Mission such as:

Institutional Framework State and District Missions have been set up in all States and UTs except U.P., Goa, Delhi and Chandigarh.

The Departments of Health and Family Welfare have been merged at the level of the GOI and the same is being replicated in the States.

The Institutional framework (Mission Steering Group, Empowered Programme Committee, Mission Directorate), at the Central and State levels have been put in place.

State launch of the Mission has been organized in Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh, Orissa, Uttaranchal and North Eastern States in which apart from the state level functionaries, the Chairmen, District Boards, District Collectors and Civil Surgeons of various districts have taken part. The State Launches have doubled up as orientation workshop for the district level functionaries.

The Mission Document; Guidelines on Indian Public Health Standards; Guidelines for ASHA; Training Modules for ASHA; Guidelines for State Health Mission; District Health Mission and merger of societies have been shared with the States.

MOU to be signed with States have been shared with the States. MOUs clearly spell out the reform commitment of the States in terms of their enhanced public spending on health, full staffing of management structures, steps for decentralization and promotion of district level planning and implementation of various activities, achievement of milestones under the leadership of Panchayati Raj Institutions.

Five Task Groups set up on the goals of the Mission, Strengthening Public Health Infrastructure, Role of PRIs, ASHA, Technical support to NRHM have completed their work.

Three Task Groups on Health Financing, District Planning and Public Private Partnerships are in the process of finalizing their recommendations. Three new Task Groups on Urban Health, Medical Education, and Financial Guidelines set up.

Programmes Reproductive and Child Health Programme - II (RCH-II) and the Janani Suraksha Yojana (JSY) launched.

Polio eradication programme intensified - cases reduced from 134 in 2004-05 to 63 (up to now).

Sterilization compensation scheme launched.

Accelerated implementation of the Routine Immunization programme taken up. Catch up rounds taken up this year in the State of Bihar, Jharkhand and Orisaa.

Ground work for introduction of JE vaccine completed.

Group work for Hepatitis vaccines to all States completed.

Auto Disabled Syringes introduced throughout the country.

State Programme Implementation Plans for RCH II appraised by the National Programme Coordination Committee set up by the Ministry. Funds to the extent of 26.14% i.e. Rs.1811.74 crore have been released under NRHM outlay.

Infrastructure Facility survey introduced.

Repair and renovation of Sub Centres under RCH II united fund of Rs.10,000 to SHCs;

Selection of 2 CHCs in each State for upgradation to IPHS.

Upgradation of CHCs as First Referral Units and Primary Health Centres to 24x7 units taken up.

Release of funds for upgradation of two CHCs per district to IPH Standards.

District Plans Strengthening of planning process in 50% of the districts of the EAG states.

ASHAs selected. Selection of ...ASHAs in progress in EAG States.

Training of the state/district level trainers of ASHAs completed. District level training taken up.

Procurement An Empowered Procurement Wing is being set up in the Ministry.

Procurement procedures are being finalized and procedural assistance being provided to the states in the procurement activities.

Technical Support to the Mission A National Health System Resource Centre (NHSRC) being set up at national level. A Regional Resource Centre set up for North Eastern States. Ground work prepared for State Resource Centres.

700 Consultants (MBA/CA) appointed for State/District Level Programme Management Units.

MOUs signed with the States clearly articulating the commitment of the States.

Training and Capacity Building Finalized comprehensive training strategy.

Training started on Skilled Birth Attendant. “

(emphasis added)

13. The scheme specifically provides for a concerted action for integrated health facilities; quality and accountability in delivery of health services; taking care of the needs of poor and vulnerable sections of society and their empowerment; preparation for health transition and appropriate health financing; pro-people public private partnership; convergence for effectiveness and efficiency and responsive health system meeting people's health needs. It has also given details of the priorities, constraints and action to overcome them. But in practice, petitioners complaint is that medical establishments at the ground level, i.e. Primary Health Centers (PHCs), Community Health Centers (CHCs), District Level Hospitals (D.L.Hs) and even State level Medical Colleges (SMCs), all are in precarious condition. Medicines are not available, Para Medical Staff is inadequate, corrupt and inefficient, Medical Officers are mainly unavailable and wherever they are, either incompetent or work with gross carelessness and negligence and find it better to refer patient(s) to Districts or other Hospitals and fail to provide even immediate threshold medical treatment. Unfortunately, even in Districts and State Medical College Hospitals, same story continue.
14. Even at KGMU, which is considered to be a finest Medical College and Hospital in State, (as claimed by State and mostly believed by the people of State), patients are forced to wait for months together for undergoing operations and treatment. This waiting period is very long, causing enhancement of sufferance, agony and pain to the patients. Nobody bothers to see that poor and needy people are not attended properly. In most Government hospitals and health care centers, treatment is refused if people are not able to cough up money and satisfy illegal demands of medical and para medical staff. Officers of Provincial Medical Services (hereinafter referred to as "PMS") like Deputy Chief Medical Officers etc. show crudest and corrupt behaviour with sufferers and their attendants. Nobody is there to take care and also to take appropriate action against erring officers in any manner. Huge funds are spent in the name of welfare medical services undertaken by State but fact is that those services are not available to real needy people but swelling pockets of those who are supposed to serve.
15. With this backdrop, by way of this Public Interest Litigation, petitioners, besides seeking compensation by way of damages for ill-treatment met to petitioner-1 in State Medical Services by Medical Officers and other staff, has also prayed for a writ of mandamus directing respondents-1 and 2 to implement strictly, directions and objectives of National Rural Health Services Guarantees, in respect of ante natal care, delivery care and post natal care and to ensure timely Referral with full documentation, honouring of Referral with free treatment till tertiary level of care. Petitioners have also sought a writ of mandamus directing respondents-1 and 2 to ensure proper treatment and medical facilities at all District Hospitals, Community Health Centers, Primary Health Centers etc., so as to ensure proper medical care and also to maintain a full "Outdoor Patient Record" including history, examination, diagnosis and advice; and in case of Referral and discharge, a comprehensive Referral and discharge record. A third prayer for mandamus is for direction to respondents-1 and 2 to set up a "Grievance Redressal Mechanism" as also a system for conducting audits of all maternal deaths and maternal complications at

District Level including investigation of system induced delays and also periodical publication of results of these audits.

16. Writ Petition (PIL) No.65217 of 2008 (hereinafter referred to as “Second Petition”) has also been filed as Public Interest Litigation by one Raj Kumar Singh, a social worker and Editor of Weekly Newspaper namely “Naha Sandesh” having Headquarter at 44, Asha Bhawan, Bhati, District Mau. In this writ petition, a mandamus has been sought directing respondents to make it mandatory that all District Private Hospitals and Nursing Homes should display qualification of Para Medical staff, their designation and they shall also bear their name tag. Further an inquiry be conducted as to how Hospitals and Clinics are running undertaking medical termination of pregnancy though in District Mau, none is registered under Medical Termination Pregnancy Rules 2003 and State Government be directed to take appropriate action in the matter.
17. In both the matters counsel for petitioner submitted that Court may concentrate in both these matters on medical services in State of U.P. and only in respect of medical termination at Private Medical Clinics and Nursing Homes, it should be made obligatory for authorities to ensure strict compliance of statute, failing which appropriate stern action be taken against erring institutions. We are proceeding to consider first issues arising from first petition.
18. In substance, extreme poor conditions of medical services in the State at various levels have been brought to the notice of this Court with special reference to women. Facts disclosed in First Petition demonstrate pathetic conditions prevailing with Medical Services maintained by State, one of the most important constitutional obligation being a “Welfare State”. State has to provide effective medical service for which huge budgetary fund is allocated every year and consumed but without ensuring whether benefits are reaching to last person for whom this entire system is working. There is no responsibility, no accountability and no sincerity towards service.
19. We need not to remind that we are governed by a dynamic, organic, well drafted people’s oriented document of governance, i.e., Constitution of India. Besides others, certain fundamental rights to citizens and residents of this country have been enshrined and guaranteed therein. Article 21 is one of the most important fundamental right, which guarantees right of life and liberty to a person. The term «right to life and liberty» has been interpreted by Courts, time and again, so as to encompass a right to live with dignity, safety and in a clean environment. Socio economic justice for people is the spirit of preamble of our Constitution. Interest of general public is a comprehensive expression comprising several issues which affect public welfare, public convenience, public order, public health, morality, safety etc. All are intended to achieve socio-economic justice for people.
20. In *Consumer Education and Research Centre v. Union of India*, (1995) 3 SCC 42, Court said that human sensitivity and moral responsibility of every State is that “all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.”

21. The jurisprudence of personhood or philosophy of the right to life envisaged under Article 21, enlarges its sweep to encompass human personality in its full blossom with invigorated health which is a wealth to the workman to earn his livelihood, to sustain the dignity of person and to live a life with dignity and equality. Article 48-A places an obligation upon Governments to protect and improve environment. Expression «life» under Article 21, has within its ambit, operational efficacy of human rights and constitutional rights, the right to medical aid and health. Court held that facilities for medical care and health to prevent sickness, ensure stable manpower for economic development and is the obligation of State. It is a fundamental right of citizens and residents of this country. Court also refers to Articles 21, 39(e), 41, 43 and 48-A of the Constitution of India.
22. Above observations have been reiterated in Court on its Own Motion vs. Union of India (UOI) and Ors., JT 2012(12) SC 503.
23. When matter came up before Court on 10.10.2017, learned counsel for petitioners stated that they are pressing writ petition with respect to reliefs-2 to 6. The matter was heard accordingly.
24. This Court noticed that only Union of India, respondent-3 had responded by filing a counter affidavit but State of U.P. and its authorities strangely abstained themselves from putting any response. Observing that “right to Health” is an integral facet of a meaningful right to life enshrined under Article 21 of the Constitution, this Court passed an order on 10.10.2017. Relevant paragraphs 12 to 16 thereof are reproduced as under:
 - “12. When right to health and medical aid is a part and parcel of fundamental right to life and liberty under Article 21 of Constitution, it includes within its ambit maintenance of health care services by State in appropriate manner, so as to take care of sickness and health problems of its residents in an appropriate manner. Poor, shabby and inadequate health care institutions, if are maintained by State, it is nothing but a blatant invasion on fundamental right of persons, which is a part of Article 21 of Constitution.
 13. It is really surprising that this matter is pending for the last eight years but State Government and its authorities have chosen to keep silence by not filing any reply till date.
 14. Before proceeding further, we find that a lot of information Court needs with regard to health care institutions being maintained by State Government and hence, its reply is also necessary. We, therefore, direct Principal Secretary, Medical Health and Welfare who is responsible for all Government Hospitals as also Secretary, Medical Education, Government of U.P., Lucknow who is maintaining hospitals connected with State Medical Colleges, to file their personal affidavits giving following details:
 - (i) Total budgetary allocations made by State Government for maintaining health and medical welfare of people in the State and items particularly covered by such allocation.
 - (ii) Funds/allocations received from Government of India towards various health

maintenance schemes launched by Government of India in the last five years.

- (iii) Total number of Government Hospitals maintained at District Level, Block level and Gram Panchayat Level. Details shall be furnished Districtwise.
- (iv) Number of medical staff and para medical staff sanctioned in the aforesaid hospitals. Details shall also be given district-wise as on 30.09.2017.
- (v) Number of medical and para medial staff actually working in the aforesaid institutions.
- (vi) Total amount spent by State on medicines supplied to patients through aforesaid hospitals.
- (vii) Number of patients attended in aforesaid hospitals month-wise in the last one year.
- (viii) Amount spent by State on regular maintenance of machines and apparatus etc., needed in aforesaid hospitals for operation and other purposes.
- (ix) Whether all District Level Hospitals as also those attached with State Medical Colleges have Trauma Centres in working condition, and, if so, since when.
- (x) Whether any medical scheme for pregnant ladies, for delivery of child and child maintenance has been launched. If so, details thereof.
- (xi) Any other Scheme relating to people health care with details.

15. Aforesaid affidavits shall be filed by two Secretaries as directed above within six weeks.

16. List this matter on 27th November 2017.”

(emphasis added)

25. Respondents-1 and 2 found more than 1-½ months' time granted on 10.10.2017, insufficient. On 27.11.2017 when matter came up, learned Additional Advocate General Sri M.C. Chaturvedi, appeared with a request to grant further time, which is usual practice, we have experienced, on the part of State. The matter was adjourned to 4.12.2017, when two affidavits were filed, one sworn by Sri Prashant Trivedi, Principal Secretary, Medical, Health and Family Welfare (hereinafter referred to as “P.S., MHFW”) and another by Rajneesh Dubey, Principal Secretary, Medical Education (hereinafter referred to as “P.S.,M.E.”) Affidavits contain certain gross collective informations but no details.
26. P.S., MHFW stated that this writ petition being Public Interest Litigation is not being contested by joining issues since matter has been raised in larger public interest. Therefore, Government would make all possible efforts to further the cause raised by petitioners and satisfy need of people with reference to quality of Medical Health Services in State of U.P. It is also said that any opinion, direction or suggestion would be positively implemented by Government in the best interest of State. Giving statistical details, pursuant to specific information sought by this

Court, it is said that Departments of Medical Health and Medical Education, though are being managed separately by officers of the level of Principal Secretary and Secretary, but proceed in a consolidated and coordinated manner so that entire paraphernalia is best utilised for the benefit of people of State. "P.S., MHFW" is responsible for all Government hospitals while, "P.S.M.E." is maintaining hospitals connected with State Medical Colleges.

27. Budgetary allocation for Medical and Health is separate. Family Welfare, Medical and Health allocation has three major heads, namely, Alopathic, Public Health and Social Welfare (Special Component Scheme). Preceding 5 year's budgetary allocation for Medical and Health Department under the aforesaid three Sections is as under:

(Rs. In Crores) S.N.

Grant No.	F.Y. 2013-14	F.Y. 2014-15	F.Y. 2015-16	F.Y. 2016-17	F.Y. 2017-18
32- Health Department (Alopathic)	4114.05	5006.76	5580.51	6344.27	6516.86
36- Health Department (Public Health)	441.47	500.87	556.67	607.92	589.88
83- Department of Social Welfare (Special Component Scheme)	21.00	21.00	30.16	104.40	101.35
Total	4576.52	5528.63	6167.34	7056.59	7208.09

28. The above chart shows a consistent increase of funds under different heads, sometimes a little bit substantial, but in recent period, increase is very nominal. In F.Y. 2017-18, under the head of Public Welfare and Social Welfare, allocation of fund has reduced than what it was in F.Y. 2016-17. We failed to understand any reason therefor inasmuch as population of State is continuously on increase and health conditions of poor people has not shown any broad improvement so as to justify reduction under any head. However, no reason even otherwise has come forward. Be that as it may, allocation of funds has been given by P.S., MHFW in his affidavit without mentioning reasons and causes of increase or decrease in funds in different periods.
29. Similarly towards Family Welfare for two years, namely F.Y. 2016-17 and 2017-18, budgetary allocation has been shown as under:

In Crores F.Y.

Allocation	Expenditure	Unspent Amount
(2016-17)	6458.0430	4965.3612
(2017-18)	6140.1807	1573.8369

30. There is a note under the aforesaid chart stating that NHM grant included in the aforesaid allocation was Rs.4576.3860 Crore in F.Y. 2016-17 and Rs.4048.3842 in F.Y. 2017-18. Expenditure in the aforesaid two Financial Years in Family Welfare Department is Rs.4965.3612 Crore in F.Y. 2016-17 and 1573.8369 Crore in F.Y. 2017-18. The aforesaid expenditure included NHM funds Rs.3453.8529 Crore in F.Y. 2016-17 and Rs. 638.7552 Crore in F.Y. 2017-18.
31. The chart of allocation of funds towards Family Welfare and expenditure shows a startling fact that huge amount remained unspent and we really failed to understand any reason therefor. Whether State lacked interest in family welfare activities or there were any other factors for non-spending of money, is a matter of simple guess as nothing has been mentioned in the affidavit

of P.S., MHFW but the fact remains that almost 24% of allocated funds in 2016-17 remained unspent and in 2017-18 also (affidavit has been filed in December, 2017 when 3/4 of Financial Year has already gone) only about 25% and odd funds have been spent and remaining is lying unused. This is bound to affect welfare activities of needy persons and State has to account for that by showing justified reason therefor.

32. Schemes launched by Government of India in the last five years and details of funds received therefor are given in Annexure-3 to the Affidavit of P.S., M.H.F.W. which read as under:

(Rs. in Lacs) S.N.

Programme Name Fund received 2012-13 Fund received 2013-14 Fund received 2014-15 Fund received 2015-16 Fund received 2016-17
 RCH Flexipool 67875.72 95633.92 74290.25 94846.66 99666.67
 Mission Flexipool 47605.16 43002.54 78996.01 110954.00 122187.92
 Immunization 7846.68 11285.01 3833.98 3856.67 3750.00

4. IPPI 12786.70 12509.00 8580.00 10725.00 6150.00 RNTCP 4309.82 5333.04 5673.33 12898.65 15037.83 NVBCD 1484.67 1336.55 3165.83 1570.84 1458.33 NIDDCP 0.00 0.00 235.44 151.67 78.33 NLEP 380.22 324.77 520.48 524.47 IDSP 344.89 382.90 386.66 375.00 562.50 NMHM 0.00 0.00 886.92 0.00 NPPCD 1.76 2.00 101.01 NBCP 1682.94 1134.33 543.02 NTCP 8.00 0.00 0.00 National prog. For health care elderly 133.72 240.86 0.00 6043.33 N.P. For control of cancer, diabetics, cardio stroke 89.29 344.73 2085.34 NOHP 0.00 0.00 0.00 0.00 NUHM 600.22 805.14 20220.99 12025.50 7545.00 Total 145149.79 172334.79 199519.26 253971.79 256436.59
 Infrastructure Maintenance 2017-18 Infrastructure Maintenance 2016-17 87446.00 155567.00 137643.70 43948.31 28628.59 Infrastructure Maintenance 2015-16 13861.29 Infrastructure Maintenance 2014-15 31167.66 Dues 2014-15 5578.64 Dues 2015-16 9712.52 Total 232595.79 327901.79 337162.96 297920.10 345385.29

33. Aforesaid chart shows that in the last five years i.e. F.Y.2012-13 to F.Y. 2016-17, funds received from Government of India under various schemes are Rs.15409.6593 Crores.
34. Allocation of funds by Central Government in various schemes has been substantial. It was more than Rs. 2300 crores in 2012-13 which increased to more than Rs. 3200 crores in next year i.e., 2013-14. In subsequent years it has continuously increased though not substantially but in any case more than Rs. 3400 crores have been allocated and released in F.Y. 2016-17. Despite such huge funds if schemes have not properly been carried out and objectives have not been achieved, than it can be said to be a sheer wastage of huge public funds. This requires investigation, where these funds have gone and who has pocketed it or why remain unspent if could not be utilized.
35. Giving details of hospitals at District, Tehsil, Block and Gram Panchayat Level, it is said that total Male/Female Combined Government Hospitals in State of U.P. are 174 with capacity of 23070 beds, Community Health Centers (hereinafter referred to as "C.H.C.") established in districts are 821 and Primary Health Centers (hereinafter referred to as "P.H.C.") are 3621.

36. Number of beds available in entire State of U.P. being only 23000 when we have presently population of about 23 crores (i.e., one bed between 10000 people). It is extremely inadequate and a self speaking fact to show deprivation of appropriate medical services to poor and needy people of this State.

37. District wise details of C.H.C. and P.H.C. and sanctioned posts of Medical Officers are as under:

S.N.

Name of Districts Number of C.H.C.

Number of P.H.C.

S.N.

Name of Districts Number of C.H.C.

Number of P.H.C.

Number of Sanctioned Posts of Medical Officers Agra Firozabad Mainpuri Mathura Aligarh KasganjEtah Hathras Allahabad Pratapgarh Fatehpur Kaushambi Azamgarh Ballia Mau Bareilly PilibhitSahjahnpur Budaun Balrampur Bahraich Gonda Sravasti Fazabad Ameti Ambedkar Nagar BarabankiSultanpur Basti Siddharth Nagar Sant Kabir Nagar Gorakhpur Deoria Kushinagar Maharajganj JhansiLalitpur Jalaun (orai) Chitrakoot Mahoba Banda Hamirpur Kanpur Nagar Kanpur Dehat FarukhabadAuraiya Etawah Kannauj Lucknow Raibareily Hardoi Unnao Sitapur Kheri Meerut BulandshahrBaghpat Gautam Budh Nagar Ghaziabad Hapur Saharanpur Muzaffar Nagar Shamli MoradabadSambhal Amroha Rampur Bijnor Varanasi Ghazipur Chandauli Jaunpur Mirzapur Sonbhadra Sant Ravi Das Nagar Total 18150

38. Number of posts of nursing staff sanctioned and working, collectively, is as under:

S.N.

Post Sanctioned Working Chief Nursing Officer Nursing Superintendent Deputy Nursing Superintendent Assistant Nursing Superintendent Sister Staff Nurse Total

39. Above chart shows that almost 50% of vacancies of Nursing Staff are unfilled. It is difficult to accept and understand, how 821 CHCs and 3621 PHCs, besides District Government Hospitals (174 in number) can be looked after by a sanctioned strength of just 1469 Sisters and 7770 Staff Nurses. The sanctioned strength apparently is highly inadequate. Even that is not occupied to its optimum level. We also find almost 60% vacancies of Sisters and 55% vacancies of Staff Nurses, unfilled. Reason for huge vacancies of these cadres has not been stated in the affidavit filed by P.S., MHFW. We also do not find any sincere attempt or concern on his part to find out why so many vacancies are continuing and steps have not been taken to fill in the same. This negligence and apathy is nothing but a fact to demonstrate that at the highest level of State nobody is sensitive enough to look into the plight of poor, needy, infirm and sick

people for whose benefit State medical services are run and that is why such a large number of vacancies have been allowed to continue and how long the same would continue, still a matter of wild guess.

40. Details of Para Medical Cadres like sanctioned strength, actual working strength and number of vacancies are as under:

S.N.

Name of Posts	Total sanctioned strength	Working strength	Vacant post
Joint Director (Pharmacy)	1	1	0
Officer on Special Duty (Pharmacy)	1	1	0
Officer in charge (Pharmacy)	1	1	0
Chief Pharmacist	1	1	0
Pharmacist	1	1	0
X-Ray Technician	1	1	0
Senior Lab Technician	1	1	0
Lab Technician	1	1	0
Physiotherapist/Occupational Therapist	1	1	0
Darkroom Assistant	1	1	0
E.C.G. Technician	1	1	0
Excess-57	57	57	0

41. In nutshell, total sanctioned Para Medical staff is 11925 which includes 389 Senior Lab Technician, 2109 Lab Technician, 1334 Chief Pharmacists, 6061 Pharmacists, 56 Incharge Officer, Pharmacy, 578 Dark Room Assistants, 65 Physiotherapists, 1074 Ex-ray Technicians and 87 ECG Technicians.
42. Despite aforesaid para-medical staff it has been demonstrated before us and during course of argument admitted that a large number of Radiological tests and Diagnosis are attended in private centers since facilities at Government Hospitals and Health Centers either found non-functional or for some other reasons the same are not available to poor and needy sick people. We find that even basic items like, stratures, ambulances etc. are not available, attendants carry their patients and many a times even dead bodies are lying in a very inhuman and insensitive manner due to apathetic concern shown by Government medical staff.
43. With respect to allocation of budget towards Medicines and Chemical Head, details have been given in Annexure 10 to the affidavit of P.S., MHFW which are as under:

(In Crores) S.N.

Financial Year	Budgetary allocation	Expenditure	Unspent budget
2013-14	390.44	379.09	011.35
2014-15	420.75	412.50	008.25
2015-16	469.87	457.67	012.20

4. 2016-17	530.97	514.46	016.51
2017-18	623.47	239.46	384.01

44. On the one hand medicines are not being made available to poor people though claimed that same are being provided free of cost and on the other hand we find that whatever budgetary allocation has been made even a part thereof remained unspent and unutilized. Why budgetary allocation towards medicine and chemicals has remained unutilized is again a matter of wild guess in absence of any explanation provided by P.S., MHFW in his affidavit.
45. It is further averred that from October 2016 to September 2017, number of persons attended in O.P.D. is 1302.60 Lacs, details whereof, as per Annexure-12 are as follows:

S.N.

Month Number of Patients attended (in Lacs) October, 2016 122.59 November, 2016 108.78 December, 2016 109.41

4. January, 2017 81.62 February, 2017 90.23 March, 2017 81.35 April, 2017 70.98 May, 2017 96.70 June, 2017 101.56 July, 2017 99.56 August, 2017 211.87 September, 2017 127.95 Total 1302.60

46. The number of patients attending OPD from aforesaid chart shows that almost for every 2-3 persons in the total population of this State, one has attended OPD. This shows level and quantum of sickness and enormity of problem. Lack of proper hygienic conditions, unplanned development, pollution of air and water, both due to various activities like reckless and illegal exploration and mining, construction activities, siphoning of natural resources without caring replacement, destruction of greenery etc., are some of the causes for continuous increase in sickness among the people. Neither State is providing post-sickness care in a better way nor taking care for effective preventive measures so that people may not fall sick. In both the ways people are on the mercy of conditions over which most of them have no control and have to suffer for the fault of a few others.
47. Total 389 posts of Senior Lab Technicians are sanctioned in all districts and in different units in the manner as under:

S.N.

Name of Districts District Hospital Blood Bank District Malaria Officer Regional Family Welfare Training Centre Maternity Wing Filaria Unit Agra 03 (Regional Malaria Lab) A.D. 01 (Dist.

Malaria Officer) Mathura Firozabad Mainpuri Aligarh Hathras Kasganj Etah Meerut 02 (Regional Malaria Lab) A.D. 01 (Dist.

Malaria Officer) Bulandshahr Ghaziabad Hapur Baghpat Gautam Budh Nagar Varanasi 03 (Regional Malaria Lab) A.D. 01 (Dist.

Malaria Officer) Chandauli Jaunpur Ghazipur Mirzapur Sant Ravi Das Nagar Sonbhadra Faizabad 03 (Regional Malaria Lab) A.D. 01 (Dist.

Malaria Officer) Ambedkar Nagar Barabanki Sultanpur Amethi Basti 04, 02 Siddharth Nagar Sant Kabir Nagar Gonda Balrampur Baharaich Shrivasti Kanpur Nagar Kanpur Dehat Kannauj Farukabad Auraiya Etawah Allahabad 03 (Regional Malaria Lab) A.D. 01 (Dist.

Malaria Officer) Pratapgarh Kaushambi Fatehpur Bareilly 03 (Regional Malaria Lab) A.D. 01 (Dist.

Malaria Officer) Budaun Pilibhit Shahjahanpur Gorakhpur 03 (Regional Malaria Lab) A.D. 01 (Dist.

Malaria Officer) Kushinagar Maharajganj Deoria Chitrakoot Mahoba Banda Hamirpur Jhansi 03 (Regional Malaria Lab) A.D. 01 (Dist.

Malaria Officer) Jalaun Lalitpur Saharanpur Muzaffarnagar Shamli Azamgarh Mau Balia Lucknow03(Regional Malaria Lab) A.D. 01 (Dist.

Malaria Officer) Sitapur Unnao Raibareilly Hardoi Lakhimpur Kheri Muradabad Bijnor RampurSambhal

48. Number of Senior Lab Technicians allocated in different districts and mostly in different hospitals show that in health care centers, availability of Lab facilities are either in very bad conditions or not available at all. A district comprises of hundreds of villages and some districts have number of villages running in four figures also, intra-district distance is also very large, transportation of patients from village to district is time consuming, and looking into all these aspects it is apparent that medical facilities at village level, are in extremely deplorable shape. Is it for the reason of conscious omission to have medical facilities of appropriate standard at village level or we pay lesser respect to the people residing in rural areas or village or for any other reason, again a matter of investigation. In the present case since no explanation has come forward, it is a matter of guess work. Fact however is evident that at grass level effective medical facilities are wanting.

49. Under the head of "Maintenance in Health and Medicines", details of budgetary allocation and expenditure in F.Y. 2013-14 to 2017-18 are given as under:

(Rs. in Crore) S.N.

Financial Year	Budgetary allocation	Expenditure	Unspent amount
2013-14	94.92	89.90	5.02
2014-15	100.72	97.34	3.38
2015-16	112.85	98.99	13.86

4. 2016-17	136.06	123.65	12.41
2017-18	124.11	31.33	92.78

50. Here again we find almost 4 to 10% of budgetary allocation unutilized and reasons therefor are not understandable as nothing has been said by P.S., MHFW in his affidavit.

TRAUMA CENTRES

51. We are told by learned counsel for parties at Bar and learned Additional Advocate General joined the statement by submitting that realizing problem of huge casualties on account of vehicular accidents, Government of India after having extensive study in developed and developing countries, decided to establish Trauma Centers across the country and atleast within access of few minutes of accident to the needy ones. We have examined on this aspect also. Going in historical aspects of Trauma Centers, which is not very old, we find that motor accidental deaths in the country were found alarming. Many a times, persons injured in accidents could not be saved due to non availability of requisite multi-specialized services at one place. World Health Organization reports said that road traffic death and injuries are predictable and preventable. Several developed and developing countries could tackle with the menace in various ways including by providing medical services with basic life support fastened and replacement of fluids within first hour of injury.

52. Taking progressive steps in India, Government of India, during 11th Plan, launched a scheme

towards road safety which may include Trauma Care Services along the Highways. The scheme with the title "Capacity Building for developing Trauma Care Facilities on National Highways" was launched during 11th Plan as a 100% central grant-in-aid scheme. Its objective was to augment Trauma Care Services at existing 140 public healthcare facilities along National Highways. It was extended and expanded in 12th Plan and fund pattern was changed by including State's share of expenditure. Government of India decided to provide consolidated funds to State and not to Trauma Care facilities directly. The objective was a better monitoring and accountability to provide above service. The critical factor for strategy of Trauma Center was to provide initial stabilization to the injured within the golden hour. The time between injury and initial stabilization is most critical period for patient's survival. Strategic activities to achieve this objective include:

- (a) Initial stabilization by trained manpower;
- (b) Rapid transportation; and,
- (c) Developed medical facilities to treat such cases.

53. Ministry of Health and Family Welfare started Piolet Project (1999) during Ninth Five Year Plan to augment and upgrade accidents and emergency services in selected State Government hospitals, located in most accident prone areas of National Highways. The scheme envisaged providing financial assistance to upgrade emergency services at selected Government hospitals.
54. With the feedback received and general consensus that emerged during consultations with various stakeholders, it was proposed to design and develop a network of Trauma Care Centres that would, in first phase, cover entire Golden Quadrilateral connecting Delhi-Kolkata-Chennai-Mumbai-Delhi and North-South-East-West Corridors.
55. The Scheme for developing Trauma Care facilities in Government Hospitals and National Highways started in 11th Plan and initially 140 Trauma Care Centers were planned to be established with a cost of Rs. 732.25 crores. In 12th Plan it was expanded to establish 85 more Trauma Care Centers of three levels, i.e., Level-I (5); Level-II (25); and Level-III (55).
56. In an operational guidelines published by Government of India, Ministry of Health and Public Welfare with the title "Capacity Building For Developing Trauma Care Facilities on National Highways", details of Trauma Care design has been given. It says that a "Trauma Care Facility" generally referred as "Trauma Care" is a Health Care Institution that has resources and capabilities necessary to provide Trauma Care at a particular level to injured patients. Trauma Center designation set criteria with strict requirements for staffing, specialist availability, response times, training, quality improvement and community education. Facility verification and designation is an important foundation for the success of an inclusive Trauma Center.
57. Trauma Centers are categorized into four levels:
 - Level IV Trauma Center: These are equipped and manned mobile hospital and ambulances provided by MoRTH / NHAI / NRHM / State Governments, etc as the case maybe.

Level III Trauma Center: It provides stabilization (surgically if appropriate) to the trauma patient. Comprehensive medical and surgical inpatient services are to be made available to those patients who can be maintained in a stable or improving condition without specialized care. Emergency doctors and nurses are available round the clock. Physicians, surgeons, Orthopaedic surgeon and Anaesthetist would be available round the clock to assess, resuscitate, stabilize and initiate transfer as necessary to a higher-level Trauma Care Service. Such hospitals will have limited intensive care facility, diagnostic capability, blood bank and other supportive services. As per scheme, District/ Tehsil Hospitals with a bed capacity of 100 to 200 beds would be selected for level III care.

Level II Trauma Center: It has to provide definite care for severe trauma patients. Emergency physicians, surgeons, Orthopaedicians and Anaesthetists are in-house and available to trauma patients immediately on arrival. It would also have on-call facility for neurosurgeons, pediatricians and if neurosurgeons are not available, general surgeons trained in neuro surgery for a period of 6 months in eminent institutions would be made available 24x7. The Center should be equipped with emergency department, intensive care unit, blood bank, rehabilitation services, broad range of comprehensive diagnostic capabilities, and supportive services. In this category existing medical college and hospitals with bed strength of 300 to 500 are identified as Level II Trauma Center.

Level I Trauma Center: It provides highest level of definite and comprehensive care for patient with complex injuries. Emergency physicians, nurses and surgeons would be in-house and available to trauma patient immediately on their arrival. The services of all major super specialties associated with Trauma Care would be available 24x7. It should be situated at a distance of less than 750 to 800 kms apart. These Level I Trauma Centers need not necessarily be along with the Highways corridor. These should be tertiary care centers to which patients requiring highly specialized medical care are referred. Level I Trauma Centers are supposed to be only in medical colleges due to high level of skill, specialists and infrastructure required for the same.

58. The aforesaid guidelines perceived distinction between "Trauma Care" and Emergency Department and clearly say as under:

Trauma Center vs. Emergency Department: The difference between an emergency department and a Trauma Center is both a matter of law and a matter of degree. As a matter of law, all hospitals are required to promptly attend to all medical emergencies, hence must have emergency services. As a matter of degree, emergency departments are designed for a broad scope of minor to severe medical emergencies. On the contrary, a Trauma Center has a focused scope of practice and strict requirements for staffing, specialist availability and response times to cater specifically to the critically injured. Based upon its capability to treat serious injuries, an emergency department can be given appropriate designation of a Trauma Care Facility as well. Emergency Departments of hospitals that are not designated Trauma

Centers may not have organized multi-speciality teams ready to respond to trauma calls or access to the immediate, high level of surgical care available at a designated Trauma Center. It is highlighted that Trauma Center is not an infrastructure concept but a System Concept in which appropriate infrastructure, equipment & human resources work in tandem to provide necessary trauma care services to a patient.

59. The planning consideration for Trauma Care Facility gives further details and it provides in said guidelines as under:

A Trauma Care Facility is within a hospital building, a separate building adjunct to an existing hospital or a stand alone facility self-sufficient in all aspects. The core areas in all these three types remain consistently the same as detailed below, the difference being primarily in scope of support facilities that needs to be planned.

Core Areas in Trauma Care Facility:

- (A) Patient Access:
 - (a) Ambulance entrance
 - (b) Walking entrance
- (B) Patient Care Areas:
 - (a) Triage and Reception area
 - (b) Resuscitation area
 - (c) Treatment area
 - (d) Ambulatory care area
 - (e) Waiting Area
 - (f) Observation Ward
 - (g) Isolation rooms
- (C) Clinical Support Services
 - (a) Lab Services
 - (b) Radiology
 - (c) Blood Bank
 - (d) Pharmacy
 - (e) Communications
 - (f) CSSD
 - (g) Manifold
- (D) Facilities for Patients Relatives
 - (a) Waiting Area
 - (b) Communication Room

- (c) Toilets
- (d) Refreshment Area (E) Staff Facilities
 - (a) Staff changing rooms
 - (b) Staff shower and toilets
- (c) Staff dining area (F) Office accommodation:
 - (a) Administrative support
 - (b) Staff offices

60. The guiding principle for running a Trauma Care Facility is uniquely time-dependent for patient's care. The length of time spent by patients waiting for, or receiving care, number of patients attending and scope of services offered influences the design requirements for each component of facility. The reception/triage, the trauma bay, the OR, the postoperative care unit, the intensive care unit (ICU), and the surgery ward form an interdependent system through which trauma patient will transit during their stay at Hospital.

61. Details of further design etc. of Trauma Centers are also given in said guideline and we are omitting the same for the time being except noticing the norms of Intensive Care Unit beds and Operation Theaters for Level-I, Level-II and Level-III Trauma Care Facility provided by Government of India.

L-I L-II L-III ICU Beds 30 beds (10-ICU and 20-General trauma beds) 20 beds (10-ICU and 10 General trauma beds) 10 beds (5-ICU and 5-General trauma beds) Operation Theaters

62. Similarly human resources are also provided in said guidelines at L-I, L-II and L-III Level Trauma Centres, as under:

S.N.

Human Resource L-1 L-II L-III Neuro Surgeon

-

Radiologist

-

Plastic Surgeon

-

-

Anaesthetist Orthopaedic Surgeon General Surgeon Casualty Medical Officer Staff Nurse (including Trauma Nurse Coordinators) Nursing attendant OT Technician Radiographer Lab Technician MRI Technician

-

-

Multi task worker Total

63. Regarding information sought by this Court whether all District Level Hospitals as also those attached with State Medical Colleges have "Trauma Centres" in working condition, and, if so, since when, it is stated that Trauma Centres are not functional in all District Hospitals. Total number of Trauma Centres in State of U.P. are 43, out of which, 27 are functional, partly based on local arrangements, and 16 Trauma Centres are not functioning. It is further stated that problem in making Trauma Centres completely functional is lack of Specialist Doctors such as General Surgeon, Orthopedic Surgeon and Anesthetist and Para Medical Staff. It is also said that process of purchase of equipments is going on. Some Trauma Centres are operating depending on local arrangements, partly.
64. Details of Trauma Centres functional and non-functional are given in Annexure-15 to the Affidavit and therefrom, we find that Trauma Centres are functional in following districts:

S.N.

Name of Districts

1. Raibareilly
2. Sahjahanpur
3. Faizabad
4. Basti
5. Jalaun
6. Etawa
7. Fatehpur
8. Lalitpur
9. Kanpur Nagar
10. Barabanki
11. Hardoi
12. Azamgarh
13. Bulandshahr
14. Firozabad
15. Unnav
16. Sultanpur

17. Saharanpur
18. Varanasi
19. Ghaziabad
20. Lucknow
21. Jaunpur
22. Kannauj
23. Banda
24. Ballia
25. Sonbhadra
26. Muradabad
27. Aligarh (Jasrathpur)

65. Trauma Centres are non-functional at following places :-

S.N.

Name of Districts

1. Sitapur
2. Jhansi
3. Muzaffarnagar
4. Hathras
5. Lakhimpur Khiri
6. Kanpur Dehat

66. Details of amount spent on construction of building of Trauma Centres from F.Y. 2009-10 upto F.Y. 2016-17 are as under:

(Rs. in Lakh) S.N.

Districts	Amount released by Central Government	Amount spent	Amount unspent	Construction of Trauma Centre
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1. Faizabad	92.70	92.70		
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2. Basti	65.00	65.00		
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3. Jaulan	65.00	65.00		
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-

4. Etawah 65.00 65.00

-

5. Fatehpur 100.98 100.98

-

6. Lalitpur 65.00 80.71 15.71 Construction of Trauma Centre by Government of U.P.

7. Saharanpur 63.44 63.44

-

8. Ghaziabad 63.44 63.44

-

9. Lucknow 71.67 69.14 2.53

10. Varanasi 63.44 63.44

-

11. Kanpur 63.44 63.44

-

12. Jaunpur 112.74 112.74

-

13. Kannauj 95.40 95.40

-

14. Azamgarh 148.33 146.37 1.96

15. Hardoi 209.95 209.10 0.85

16. Bulandshahr 180.12 180.12

-

17. Barabanki 148.46 148.26 0.20

18. Unnao 154.35 154.35

-

19. Sultanpur 157.30 157.29 0.01

20. Sonbhadra 150.62 150.10 0.52

21. Ballia 172.65 169.45 3.20

22. Firozabad 196.25 196.25

-

23. Banda 238.98 236.76 2.22
 24. Jhansi 175.24 175.24
 -
 25. Moradabad 186.19 175.69 10.50
 26. Sitapur 231.13 231.13
 -
 27. Kanpur Dehat 172.12 171.60 0.52
 28. Muzaffarnagar 188.36 173.00 15.36
 29. Aligarh 214.95 202.16 12.79
 30. Hathras 201.55 197.35 4.20
 31. Allahabad 170.05 165.00 5.05
 32. Hapur 97.31 97.00 0.31
 33. Mirzapur 75.36 51.02 24.34
 34. Kheri 190.38 179.69 10.69
 35. Bijor 83.10 83.10
 -
 36. Pratapgarh 84.11 84.00 0.11
 37. Bahraich 168.76 31.10 137.66
 38. Pratapgarh (Lalganj) 80.96 55.00 25.96
 39. Mainpuri 112.15 48.88 63.27
 40. Pratapgarh (Raniganj) 92.03 27.47 64.56
 41. Ghazipur 88.91 19.47 69.44
 42. Ghazipur (PHC Yusufpur) 88.91 0.00 88.91
 43. Sant Ravidasnagar 81.32 0.00 81.32 Total 5527.15 4916.38 642.19

67. Details of Nursing Staff sanctioned and presently working at various Trauma Centres, are given in Annexure-8 as under:

S.N.

Tauma Centre at Staff Nurse Sanctioned Working Trauma Centre, Kanpur Trauma Centre, Faizabad Trauma Centre, Basti Trauma Centre, Jalaun Trauma Centre, Etawah Trauma Centre, Fatehpur Trauma Centre, Lalitpur Trauma Centre, Barabanki Trauma Centre, Hardoi Trauma Centre, Ghaziabad Trauma Centre, R.M.L. Lucknow Trauma Centre,

Jaunpur Trauma Centre, Kannauj Trauma Centre, Pt. Din Dayal Varanasi Trauma Centre, Bulandshahr Trauma Centre, Firozabad Trauma Centre, Banda Trauma Centre, Azamgarh Trauma Centre, Unaav Trauma Centre, Sonbhadra Trauma Centre, Ballia Trauma Centre, Sitapur Trauma Centre, Jhansi Trauma Centre, Moradabad Trauma Centre, Lakhimpur Kheri Trauma Centre, Hathras Trauma Centre, Saharanpur

68. Thus at Allahabad, Trauma Centre is under-construction and non-functional according to above information.
69. With regard to information pertaining to medical scheme for pregnant ladies, delivery of children and child maintenance, it is stated that various schemes have been launched, details whereof are as under:
- (i) Janani Suraksha Yojna (JSY) has been launched for the benefit of pregnant lady for the financial year 2017-2018 (From April 2017 to October 2017), under which, the total number of beneficiaries are 13,72,861.
 - (ii) Janani Shishu Suraksha Karyakram (JSSK) has been launched for the benefit of pregnant lady for the financial year 2017-2018 (From April 2017 to October, 2017), under which, the total number of beneficiaries are 99,67,779.
 - (iii) Pradhanmantri Surakshit Matritva Abhiyaan (PSMA) has been launched for the benefit of pregnant lady for the financial year 2017-2018 (From April 2017 to October, 2017), under which, the total number of beneficiaries are 3,42,961.
 - (iv) In order to provide effective diabetes management system, a Gestational Diabetes Management (GDM) Scheme has been launched. The programme is running in 18 Divisional District Headquarters as Pilot Project and in those 18 Districts, trained staff has been provided, whose training has already been completed on 24.04.2017 and necessary equipments like Glucometers, Lancet and Strips procurement has been completed in all 18 Districts.
 - (v) However, regarding child maintenance keeping its commitment to decrease IMR (Infant Mortality Rate) Government of Uttar Pradesh has implemented Facility Based New born Care Program in State. Under this program following units are being established in phased manner across the State.
 - (vi) Newborn Care Corners (NBCC) have been established in labour rooms to provide immediate care to Sick new born.
 - (vii) Newborn Stabilization Units (NBSU) are being established at FRUs/CHCs for treatment of sick new born as per GOI Guidelines. Severely sick new born referred to higher centre after stabilization. Since April 2017 to September 2017 total 11376 newborns had been treated.
 - (viii) Sick Newborn Care Units are being established in phased manner across the State at DWH, other district level hospitals and selected medical colleges to care and manage sick and critical new-born babies till 28 days of life. Total admission in last year from April 2016

to March 2017 is 55288 and from April 2017 to October 2017 is 52511.

70. It is further stated that following schemes relating to the diseases of Tuberculosis, Leprosy, Infectious diseases, Encephalitis, Blindness, Polio etc. have been launched:
- i. Revised National Tuberculosis Control Programme (RNTCP)
 - ii. National Leprosy Eradication Programme (NLEP)
 - iii. Infectious diseases Surveillance Programme (IDSP)
 - iv. Acuted Encephalitis Syndrome/Japanes Encephalitis Syndrome (AES/JES)
 - v. National Blindness Controal Programme (NBCP)
 - vi. National Vector Born Diseases Control Programme (NVBDCP)
 - vii. Non-communicable disease (NCD)
 - viii. National Immunization Programme (NIP)
 - ix. Pulse Polio Programme (PPP)
 - x. National Tobacco Control Programme (NTCP)
 - xi. National Mental Health Programme (NMHP)
 - xii. National Iodine Deficiency Disorders Control Programme (NIDDCP)
 - xiii. National Fluorosis Control Programme (NFCP)
- Medical Education and attached Hospitals
71. P.S.M.E. Sri Rajinesh Dubey in a separate affidavit has said that Department of Medical Education plays a pivotal role in developing Medical and Para Medical personnel to cater health needs of State. It also plays role in establishment and maintenance of well-equipped teaching institutions which are premier referral Centres for peripheral hospitals. Medical Education Department facilitates a comprehensive medical education via various Medical, Dental Institutes, Universities and Para Medical Colleges in State of U.P. There are 13 Medical Colleges, 2 Medical Universities, 4 Autonomous Medical Institutes, 2 Non-Autonomous Medical Institutes in State of U.P., details whereof are as under:

S.N.

Name of the Institution Details

1. Medical Colleges

- (i) Allahabad
- (ii) Kanpur
- (iii) Agra
- (iv) Meerut
- (v) Jhansi
- (vi) Gorakhpur
- (vii) Ambedkar Nagar
- (viii) Kannauj
- (ix) Jalaun
- (x) Saharanpur
- (xi) Azamgarh

(xii) Banda

(xiii) Badau

2. Medical Universities

(i) King George Medical University, (KGMU), Lucknow

(ii) U.P. Ayuvigayan University Safai, Etawah

3. Autonomous Universities

(i) Sanjay Gandhi Post Graduate Institute, (SGPGI), Lucknow

(ii) Dr. Ram Manohar Lohia Institute (RML), Lucknow

(iii) Govt. Institute of Medical Sciences Greater Noida,

(iv) Super Speciality Pediatric Hospital and Post Graduate Teaching Institute, Noida
Non-Autonomous Medical Institutes

(i) J.K. Cancer Institute

(ii) Laxmipati Singhanian Cardiac Institute, Kanpur

72. Budgetary allocation for Medical Education in F.Y. 2016-17 and 2017-18 and Institutions are details as under:

(Rs. in Lacs) S.N.

Head under which amount was spent	F.Y. 2016-17	F.Y. 2017-18	Budgetary allocation	Expenditure	Budgetary allocation	Expenditure	Pay
Head under which amount was spent	14492.43	17317.99	38362.76	17796.73			
Wages	0.60	0.38	1.00	0.00	Dearness Allowance	19702.88	12775.91
Travelling Allowance	28.75	48.78	28.75	10.35	Transfer Travel Allowance	8.75	0.67
Other Allowances	1539.58	1205.73	1877.45	806.90	Honorarium	0.40	0.31
Office Expenditure	73.84	72.85	73.84	45.90	Electricity Liability	4415.00	4775.32
Water Tax/Sewarage	568.80	622.16	568.80	406.16	Stationery and printing of forms	51.38	52.55
Office Furniture and Equipments	375.80	214.25	100.80	4.62	Expenditure on Telephone	13.15	9.93
Staff Car and Other Vehicles	120.00	2.20	50.00	0.00	Maintenance of Vehicles and Petrol	57.65	53.47
Expenditure for Commercial and Specialised Services	4848.53	4709.96	4843.53	2561.05	Rent, Cess and Ownership Tax	904.00	1326.90
Publication	6.20	3.62	6.20	1.07	Advertisement, Sale etc.	15.50	7.12
Grant in Aid-General (Non-salaried)	39495.00	37305.03	35366.01	27133.12	Scholarship and Stipend	14892.81	13535.50
Large Construction Work	218401.13	173570.91	100494.04	31359.77	Small Construction Work	156.30	154.80
Machines, Equipments	47550.02	42650.00	13232.02	400.00	Maintenance	3108.05	1739.08
Investment/Loan	100.00	0.00	100.00	0.00	Grant in Aid- General (Pay)	94500.00	88500.00
Medicines and Chemicals	6327.07	5974.48	6327.07	3367.18	Requirements		

Relating to Hospitals 97.20 85.00 95.20 47.49 Food Expenditure 265.05 305.44 265.05
 187.04 Other Expenditure 673.55 917.10 635.25 405.50 Material and Supply 1098.30
 1309.70 1048.30 802.43 Journey for Training and Other incidental Expenditure 1.73 0.10
 1.64 0.00 Leave Travel Concession 9.44 0.60 9.35 0.00 Computer Hardware/Software
 Expenditure 70.66 69.11 1047.66 2.08 Maintenance of Computer and Stationery 44.70
 46.01 44.70 25.43 Medical Expenditure 170.50 197.92 102.30 76.67 Uniform Expenditure
 6.80 3.35 6.80 0.47 Arrears of Revised Pay (State) 0.00 0.00 2313.70 0.00 Arrears of Revised
 Pay (State) 0.00 0.00 6036.99 0.00 Total 474191.55 409564.23 352544.80 174489.02

73. Funds received from Government of India under Health Maintenance Schemes in the last five years are detaild as under:

(Rs. in Crores) S.N.

Name of Scheme Funds/ Allocations received from Government of India Establishment
 of new medical colleges 500.10 Enhancement of Post Graduate (PG) 35.25 Establishment
 of Trauma Centres 57.78 ICMR (Indian Counsel of Medical Research) 23.0451 Total
 616.1751

74. Funds received for Medical Colleges are in respect of State Medical Colleges at Faizabad, Basti, Bahraich, Firozabad and Shahjahanpur. Funds were received for establishing "Trauma Centres" in Government Medical Colleges at Kanpur, Allahabad, Jhansi, Gorakhpur, Agra and Meerut.

75. With regard to sanctioned strength of Doctors in Medical Colleges/Institutes/Universities, it is said that total 3389 posts are sanctioned in various categories, out of which, 2162 are filled (1760 on regular basis and 402 on contractual basis. 1227 posts are vacant. Process for selection of vacant seats has already been initiated. Details of sanctioned posts, working staff and existing vacancies are as under:

S.N.

Name of Medical College Posts Sanctioned Filled Total no. of posts filled Posts Vacant
 Regular Contract-ual Kanpur Professor Associate Professor (Sah Acharya Lecturer/ Assistant
 Professor Others (LMO, Veterinary Officer) Heart Instiute, Kanpur Professor Associate
 Professor (Sah Acharya Lecturer/ Assistant Professor J.K. Cancer Institute, Kanpur Professor
 Associate Professor (Sah Acharya Lecturer/ Assistant Professor

-3 Allahabad Professor Associate Professor (Sah Acharya Lecturer/ Assistant Professor
 Others (LMO, Veterinary Officer) Agra Professor Associate Professor (Sah Acharya
 Lecturer/ Assistant Professor Others (LMO, Veterinary Officer) Jhansi Professor Associate
 Professor (Sah Acharya Lecturer/ Assistant Professor Others (LMO, Veterinary Officer)
 Meerut Professor Associate Professor (Sah Acharya Lecturer/ Assistant Professor Others
 (LMO, Veterinary Officer) Gorakhpur Professor Associate Professor (Sah Acharya Lecturer/
 Assistant Professor Others (LMO, Veterinary Officer) Ambedkar Nagar Professor Associate
 Professor (Sah Acharya Lecturer/ Assistant Professor Others (LMO, Veterinary Officer)

Kannauj Professor Associate Professor (Sah Acharya Lecturer/ Assistant Professor Others (LMO, Veterinary Officer) Jalaun Professor Associate Professor (Sah Acharya Lecturer/ Assistant Professor Others (LMO, Veterinary Officer) Azamgarh Professor Associate Professor (Sah Acharya Lecturer/ Assistant Professor Others (LMO, Veterinary Officer) Saharanpur Professor Associate Professor (Sah Acharya Lecturer/ Assistant Professor Banda Professor Associate Professor (Sah Acharya Lecturer/ Assistant Professor Badaun Professor Associate Professor (Sah Acharya Lecturer/ Assistant Professor RMLIMS, Lucknow Professor Associate Professor (Sah Acharya Lecturer/ Assistant Professor U.P. Ayurvedic Sansthan, Safai, Etawah Professor

-5 Associate Professor (Sah Acharya Lecturer/ Assistant Professor S.G.P.G.I., Lucknow Professor Associate Professor (Sah Acharya Lecturer/ Assistant Professor K.G.M.U., Lucknow Professor

-78 Associate Professor (Sah Acharya Lecturer/ Assistant Professor S.S.P.G.T.I., NOIDA Professor Associate Professor (Sah Acharya Lecturer/ Assistant Professor Rajkiya Ayurvedic Sansthan, NOIDA Professor Associate Professor (Sah Acharya Lecturer/ Assistant Professor

76. Aforesaid chart strangely enough demonstrate a very pathetic state of affairs, inasmuch as almost in all State Medical Colleges a large number of vacancies of Teachers are existing. At some places existing vacancies are to the extent of 50% of sanctioned strength. For example, in Ambedkar Nagar against 24 sanctioned posts of Professors and 29 Associate Professors, existing vacancies are 20 and 26, respectively. Similarly, in Kannauj, against 24 sanctioned posts of Professors and 28 posts of Associate Professor, number of existing vacancies are 15 and 11, respectively. At Budaun, even in the cadre of Lecturer/Assistant Professor, against sanctioned strength of 40, 22 are vacant. In K.G.M.U., Lucknow which is a pioneer institution, vacancies of Lecturer/Assistant Professors are 245 against sanctioned strength of 414, meaning thereby that almost 60% posts are vacant. Similarly, at SGPGI, Lucknow, vacancies of Lecturers/Assistant Professors are 84 against sanctioned strength of 254 i.e. almost one-third posts are lying unfilled and in the cadre of Associate Professors, all 19 sanctioned posts are lying vacant. Another prestigious institution at Safai, (Etawah), we find that in the cadre of Lecturers/Assistant Professors, against sanctioned strength of 162, 77 vacancies are existing. This quality and standard of medical education in State of U.P., in the light of these facts, is self speaking and we find it difficult to express the same in words.

77. Similarly in the aforesaid Medical Colleges/Institutes/ Universities, etc., Non-Teaching Staff's sanctioned posts in different categories, working and vacancies are as under:

S.N.

Medical College/ Institute/ University Sanctioned Posts Posts filled Vacant Posts Group 'B' Group 'C' Group 'D' Group 'B' Group 'C' Group 'D' Group 'B' Group 'C' Group 'D' Kanpur Agra Meerut Allahabad Jhansi Gorakhpur Kannauj Jalaun Ambedkar Nagar Azamgarh Saharanpur Banda Badau Heart Institute, Kanpur J.K. Cancer Institute, Kanpur

K.G.M.U., Lucknow RMLIMS, LucknowSGPGI, Lucknow RIMS, Safai, Etawah SSPHGTI, NOIDA Rajkiya Ayurvigyan Sansthan, NOIDATOTAL Grand Total 18070

78. Like teaching staff, non-teaching staff is also largely vacant almost to the extent of 50% inasmuch as against sanctioned strength of 18070 actual working staff are 9146 and 8924 posts are vacant. Individually, in some places, vacancies are to the tune of 80 to 90%.

48. Under Head of "funds received for Medicines", details for F.Y.2015-16, 2016-17 and 2017-18 are given as under:

(In Lacs) S.N Medical College/Hospital Budgetary Allocation in F.Y. 2015-16 Budgetary Allocation in F.Y. 2016-17 Budgetary Allocation in F.Y. 2017-18 Sanctioned Sanctioned Expenditure Sanctioned Expenditure Sanctioned SN Hospital, Agra 453.00 453.00 650.00 555.33 400.00 LLR Hospital, Kanpur 570.00 570.00 794.00 793.99 528.00 New Swaroop Rani Nehru Hospital, Allahabad 533.10 531.82 670.00 479.59 400.00 Vaksh Hospital, Kanpur 57.50 57.52 63.25 63.25 63.25 Apar India Hospital, Kanpur 78.20 78.18 75.02 75.02 75.02 Maharani Lakshmibai Hospital, Jhansi 453.00 452.98 650.00 424.68 400.00 Sardar Valabhbbhai Patel Hospital, Meerut 609.00 608.92 782.40 696.54 532.40 Nehru Hospital, Gorakhpur 624.00 623.94 782.40 771.25 532.40 Contagious Decease Hospital, Kanpur 27.50 27.49 30.00 29.99 30.00 Medical College, Gorakhpur 150.00 148.24 165.00 149.94 165.00 Heart Institute, Kanpur 441.50 441.50 650.00 650.00 400.00 J.K. Cancer Insitute, Kanpur 80.00 60.64 100.00 67.44 50.00 Medical College, Azamgarh 247.50 247.50 325.00 324.93 300.00 Medical College, Banda 118.54 118.22 200.00 146.16 100.00 Medical College, Badau 100.00 90.81 300.00 197.28 300.00 Medical College, Kannauj 230.00 229.99 436.25 435.15 350.00 Medical College, Jalaun 233.00 232.83 250.00 249.81 150.00 Medical College, Saharanpur 300.00 179.87 350.00 258.80 350.00 Medical College, Ambedkar Nagar 350.00 349.99 350.00 350.00 350.00 MD Eye Hospital, Allahabad 0.00 0.00 0.00 0.00 0.00 Para Medical College, Jhansi 0.00 0.00 0.00 0.00 2.00 Total 5655.84 5503.44 7623.32 6719.15 5478.07

79. On the one hand, poor people are not being properly supplied medicines as is complained by petitioners in a demonstrable way and on the other hand, we find that in two F.Y. of 2015-16 and 2016-17 in most cases, allocated funds have not been completely utilized and a substantial amount has been left unspent. Condition of Hospitals attached with Medical Colleges at Allahabad, Jhansi, Meerut, and Saharanpur has been miserable inasmuch as at Allahabad, in F.Y. 2016-17, Rs. 670 Lacs were sanctioned but only Rs. 479.59 Lacs could be spent. Similarly at Jhansi, Rs. 650 Lacs were sanctioned and Rs. 424.68 Lacs were spent. This negligence in keeping budgetary allocation unspent and that too under the Head of "Medicines", which are to be provided to patients free of cost, is nothing but a serious negligence on the part of authorities concerned. We are surprised that no action has been taken in the matter. There is a complete lack of sense of accountability and answerability

80. With regard to Autonomous Medical Institutes and Medical Universities, it is said that procedure

of allotment of budget is different as they are allocated lump sum money under the umbrella of Non-Salary Head for miscellaneous purposes, including supply of medicines. Besides, there is provision of revolving fund for drugs and consumables in SGPGI and RML, Lucknow, in which money charged from patients is deposited and payment to drug manufacturers are made for drugs and consumables. Detailed allocation for F.Ys. 2015-16, 2016-17 and 2017-18, for these institutes are as under:

(In Lacs) S.N.

Institution/Medical College	F.Y. 2015-16	F.Y. 2016-17	F.Y. 2017-18	Grant in Aid Expenditure
Grant in Aid Expenditure Sanjay Gandhi Postgraduate Institute of Medical Sciences	8000.00	5000.00	11700.00	6000.00
Dr. RMLIMS, Lucknow	2500.00	3500.00	2500.00	4000.00
RIMS, Safai, Etawah	3615.00	5000.00	3965.00	0.00
KGMU, Lucknow	7160.00	3200.00	9900.00	15500.00
Cancer Institute, Lucknow	1000.00	4600.00	1000.00	Centre of Bio Medical Research, Lucknow
495.00	300.00	450.00	300.00	450.00
RIMSR, Safai, Etawah	850.00	300.00	1100.00	0.00
1100.00	0.00	1100.00	0.00	1100.00
Super Speciality Bal Hospital and Post Graduate Institute, NOIDA	500.00	2700.00	2700.00	Medical College, Greater Noida
500.00	750.00	300.01		

81. In the prestigious institution like SGPGI, Lucknow, RIMS, Safai, Etawah and other institutions condition of budgetary allocation and expenditure is really deplorable. In SGPGI against aid of Rs. 8000 Lacs in F.Y. 2015-16 only Rs. 5,000 Lacs utilized and in F.Y. 2016-17 Rs. 11,700 Lacs were allocated whereagainst only Rs. 6,000 Lacs could be spent. In F.Y. 2017-18 Rs. 11,700 Lacs has been sanctioned but till December, 2017 when the affidavit was filed only Rs. 400 Lacs has been spent. This is beyond comprehension to the mind of a prudent person particularly when number of patients visiting these institutions is very large.
82. With regard to patients attending Government Medical Colleges/Medical Institutes and Medical Universities, it is said that from December, 2016 to November 2017, 1,00,77,823 Outdoor patients and 7,60,528 Indoor patients were attended. Further break up at Medical College/Institutes/University-wise is given in Annexure-10 to the Affidavit.
83. In F.Y. 2016-17, Budgetary Allocation for maintenance of machines and apparatus is that of Rs. 1190.36 Lacs; For F.Y. 2017-18 it is Rs. 2400 Lacs out of which only Rs. 1775.52 Lacs has been released.
84. P.S., M.E. has also stated that in 11th Five Year Plan, Trauma Centres have been established in Government Medical Colleges at Kanpur, Allahabad, Jhansi, Gorakhpur, Meerut and Agra. Budgetary Allocation therefor is detailed as under:

(Rs. in Lacs) S.N.

Name of Medical College	Amount Sanctioned	Amount Released	Unspent Amount
Kanpur	963.00	659.00	304.00
Agra	963.00	659.00	304.00
Allahabad	963.00	735.00	228.00
Jhansi	963.00	855.00	108.00
Gorakhpur	963.00	811.00	152.00
Meerut	963.00	80.00	883.00

Total 5778.00 3799.00 1979.00

85. It is also said that Trauma Centres are in working condition in Medical Colleges of Kanpur, Agra, Allahabad, Jhansi and Gorakhpur and they are functional for the last 3 to 4 years. Exact averments contained in para 11 of the affidavit of Dr. Rajneesh Dubey, PSME reads as under:

"Trauma Centres are in working condition in medical colleges of Kanpur, Agra, Allahabad, Jhansi and Gorakhpur and they are functional for the last three to four years. The Trauma Centres of Meerut medical college is in process. One Trauma Centre in Lucknow is being handed over from KGMU to SGPGI Lucknow. Already another trauma centre in KGMU and one trauma centre in U.P. AyurVigyan (Medical) University, Safai, Etawah, are running smoothly for the last few years." (emphasis added)

86. With regard to Schemes for Women Welfare, affidavit of P.S.M.E., in para 12, says as under:

"That with regard to point no. (xi) of order dated 10-10-2017 of this Hon'ble Court, it is submitted that vide G.O. Of women welfare Department of Govt. Of U.P. Dated 14-09-2016 regarding the establishment of new Burn Units in 05 medical colleges of the state for the acid attack women victims under the Rani Laxmi Bai Mahila Samman Kosh have been sanctioned. Copy of which is being annexed herewith and is marked as Annexure No.14 to this affidavit. It is further submitted that burn wards are running in 12 state medical colleges, except Badaun Medical College."

87. Allocation of funds to different Medical Colleges vide Government Order dated 14.09.2016 (Annexure 14 to the affidavit) is as under:

(Rs. in Lacs) S.N.

Name of Institution Amount BRD Medical College, Gorakhpur 752.00 LLRM Medical College, Meerut 542.28 MN Medical College, Allahabad 616.13 MLB Medical College, Jhansi 205.66 SN Medical College, Agra 335.03 Total 2451.10

88. When these two affidavits were filed on 4.12.2017, learned counsel for petitioner disputed certain facts stated therein and also pointed out that various facts stated therein are vague and details have not been given. On several other aspects, facts stated are incorrect. For example, in the affidavit of P.S.M.E. it is said that Trauma Centres are functional in certain Medical Colleges including Allahabad for last 3 to 4 years but this is factually incorrect. It was a serious allegation made by petitioners' counsel. Therefore we found it appropriate to have those facts verified so as to test veracity of facts disclosed in the two affidavits. We, therefore, passed an order on 04.12.2017, appointing an "Advocates Commission" consisting of two Advocates to visit District Government Hospitals as well as Hospital attached to Medical College, Allahabad and submit report. Paragraphs 3 and 4 of our order dated 4.12.2017 reads as under:

"3. We, therefore, find it appropriate to appoint an Advocates Commission consisting of Sri Rajeev Sharma, Advocate, and Sri Pradeep Kumar Pandey, Advocate, who shall visit District

Government Hospitals in Allahabad City as also Medical College Hospital to find out the conditions of working position of staff etc. and submit report by 06.12.2017.

4. District Magistrate, Allahabad is directed to provide conveyance facility to the aforesaid Advocates. Senior Superintendent of Police, Allahabad shall provide Police Escort for their safety and security in discharge of aforesaid function. Besides, we also direct Chief Medical Officer, Allahabad and Principal, Allahabad Medical College to provide all assistance including making requisite information available to the aforesaid Commission for compliance of this order. " (emphasis added)
89. Two Advocate Commissioners Sri Rajiv Sharma and Pradeep Kumar Pandey visited Medical College's Hospital i.e. Swaroop Rani Nehru Hospital. They also visited District Hospitals i.e. Moti Lal Nehru Hospital (Kalvin Hospital), Taj Bahadur Sapru (Beli) Hospital and Government T.B. and Chest Hospital, Taliarganj.
90. Swaroop Rani Nehru Hospital is attached to Medical College while remaining three are maintained by Department of Medical, Health and Social Welfare.
91. Commissioners' Report in respect of Trauma Centres at Hospital/Medical Colleges reads as under:

"Medical College Hospital

1. That on inspection of medical college hospital it was found that the building of newly constructed Trauma Centre was incomplete. On enquiry, the Principal of Medical College informed that it would take at least two months of rapid work for completion only after he receives the fund sought by him from the State Government in this regard.
2. That regarding the machines and equipment to be placed in this Trauma Centre, the Principal informed that these machines have been placed in the store-room of one of the Operation Theatre which was also under repairs. All these machines were found to be locked in the store room but it was informed that they are used as and when required.
3. That it was also informed that the emergency room is being used as partial Trauma Centre. There were 6 beds in it in which oxygen equipment was connected only with 2 beds. It was informed that the patients after being given initial treatment are sent to the respective departments. The general condition of the emergency room was very pathetic.
4. That two out of the three patients admitted over there, made complaints for the delay in attending them.
5. That the condition of emergency ward was all the more horrible. It was very difficult to breath over there by a normal man. There was no A.Cs. The windows were blocked by the fixed glass. Thus there was no scope for any fresh air or any cross ventilation. One of the patients who was brought from ICU, was repeatedly requesting for being shifted back to ICU or to any other place.

6. That at the registration counter, there was huge rush of male and female patients with majority of them standing over there for more than 40 minutes. This was so despite the fact that there were 5 counters for registration and distribution of parchas.
7. That there was only one MRI machine and it was found that there was backlog of 20 days. The current patients were being given the date of 28 December, 2017 for MRI. The Principal as well as the Doctors available over there informed that this pendency is due to non-availability of technicians. Not a single technician has been provided by the supplier of the MRI machine. This technician also is working without payment on the pretext of getting the job when the post of technician is sanctioned by the government. This technician is said to be time taking as he has to attend the patients, their positions as well as the machines.
8. That there was only one C.T. Scan Machine but there were no patients around it nor anybody was found waiting for the same. When asked about it, the doctors available over there informed that there was no pendency of patients except in exceptional cases where medicines etc. are to be given before C.T. Scan.
9. That on visit to general ward when the C.T. Scan reports kept on the side of the patients' beds were checked, it was found that they were not from medical college. C.T. Scan reports of three patients were kept on the table near their bed and all of them were from outside when asked all the three patients informed that they were directed by the hospital staff to get the C.T. Scan from outside.
10. That the patients informed that several private ambulances (Maruti Van) remain standing inside the campus of medical college for taking their patients to private C.T. Scan and MRI Centre. When this fact was checked, two Vans bearing number U.P. 70 ET 6474 and U.P. 70 ET 6087 were found standing for carrying the patients to private C.T. Scan and MRI Centre. One attendant of the patient namely Mahendra Pandey having mobile no. 9335420584 informed that he was referred by the staff of Medical College to United Diagnostic for C.T. Scan.
11. That the condition of ICU Cardio was also not proper. There were 18 beds in the ICU and 22 beds outside it but there were only 2 ventilators and only 5/6 monitors were operational. So clearly there was requirement of more ventilators and more operational monitors.
12. That this ICU Cardiology was also suffering from suffocation as the windows were blocked by fixed glass and there was no scope for any fresh air on cross ventilation. No doubt some window A.Cs. were there but in the month of December, there was no question of turning them on.
13. That on the question of cleanliness it was informed that this is done only in one shift.
14. That the Principal and his staff informed that when the medical college was established in the year 1961, there were only 300 beds but the sanctioned strength of ward boys was 104. Now in 2017 the numbers of beds have been increased from 300 to 1200 but the sanctioned strength of ward boys still remains the same at 104.

15. That the Principal and staff of Medical College themselves drew the attention of commission towards-

- a) garbage concentration inside the campus as there was no disposal of waste by the officials of Nagar Nigam despite their repeated requests.
- b) there were many strayed animals like cows, buffaloes and dogs inside the campus which are continuous source of nuisance for patients as well as staff.
- c) there were many unauthorized vendors of fruits, tea, samosas and golgappas inside and immediate outside the campus. All these vendors are not turned out despite repeated complaints made to the police. These unauthorized vendors create a nuisance in the movement of ambulances of the Medical College.
- d) some of the young doctors made request that they have not been allotted a flat inside the campus and they have to rush to the Medical College from distant places like Nani in odd hours. This allotment of flats is done by the District Magistrate and many of the flats are allotted to persons who are not even in medical profession.
- e) No security staff in available to ensure smooth functioning of medical college and protection of the belonging of the patients. The Princiopal and staff of the Medical College expresses their inability to engage private security staff as the permission of the government is not there. "

92. With respect to other three Hospitals, report reads as under:

"Moti Lal Nehru Hospital (Kalvin Hospital)

1. That on inspection of this hospital, it was found that there was no-

- a) ICU
- b) CCU
- c) Cardiology Unit
- d) Ventilators
- e) Oxygen concentration

2. That on verification it was informed that there were 1869 OPD patients/fresh registration-parchas on 05.12.2-17 alone. Apart from this, the total strength of beds was 156 and almost all the beds were occupied. In such a huge turnout of patients, the above facilities should have been there.

3. That there was just two registrations counters to tackle such huge rush of patients.

4. That the commission was shown of two wards of 25 beds each. They are nicely constructed wards but there were no patients in it and it was informed by the Chief Medical Superintendent that it was not functional because of the non-availability of staff nurses. If the sanctioned post of nurses are promptly filled, these two wards can be made operational.

5. That it was also informed that there are 73 sanctioned post of Class-IV employees out of which 20 posts are vacant and no appointment has been made since 2008 on there Class-IV posts.
6. That there was only one lift and that too was out of order.
7. That the toilets were in extremely bad shape despite the fact that the staff had full knowledge of the visit of the commission.
8. That the Bio-medical waste management facility for disposal of garbage was available in the hospital and it was fully functional strangely enough this facility is not there in the medical college.
9. That the commission wanted to inspect the operation Theatre but it was locked and its keys could not be found despite waiting for reasonable amount of time.

Tej Bahadur Sapru (Beli) Hospital

- 1) That on inspection it was found that the newly constructed Trauma Centre was in good shape but it was not functional because of the non-availability of equipments and the requisite manpower to handle it. It was informed that in order to run the Trauma Centre, 6 Doctors, 2 Anesthetic, 2 Orthos and 2 General Surgeon alongwith 18 nurses are required.
- 2) That strangely enough the situation is vice versa in Medical College where equipments and staff is available for Trauma Centre but the structure is incomplete whereas in this hospital the structure of Trauma Centre is complete but equipment and staff is not available.
- 3) That neither the ventilation nor the central oxygen plant was found in the hospital.
- 4) That there ware only 5 private wards which are much less and there is a requirement of more private wards.
- 5) That the hospital has strength of 199 beds plus 10 beds in Trauma Centre. Majority of these 199 beds were found to be occupied.
- 6) That considering the huge area and the strength of beds, the necessity of 250 KWA generator was being felt by the CMS as well as staff of the hospital.
- 7) That the commission found one ambulance with life supporting system inside the hospital. On verification, the Chief Medical Superintendent informed that there are 2 ambulances with life supporting system but there is hardly any use of the second ambulance. The hospital will have no objection if the second ambulance is sent to the Medical College for the welfare of serious patients. The CMS further informed that Medical College does not have any such ambulance. The CMS also informed that the payment for 70Km. Per day per ambulance is made whether there is any actual use of the same or not.

Govt. T.B. and Chest Hospital, Teliarganj "

- 1) On inspection of this hospital, it was found that the main gate of the hospital was locked and there was no one to open it.

- 2) Consequently the commission had to enter the hospital from the side gate. The emergency room was also locked and no doctor including one on emergency duty was available. However later on one doctor turned up.
 - 3) That there are 156 beds for chest T.B. patients and 28 beds for Multiple Drug Resistant ward. The occupancy of today i.e. 05.12.2017 was reported to be 116.
 - 4) That the shortage of nurses and Class-IV employees were reported.
 - 5) That there are no oxygen pipeline and no ambulances in the hospital. The necessity of oxygen pipeline is strongly felt for chest T.B. patients."

(emphasis added)
93. Above report is self speaking, explaining in detail unfortunate, pathetic conditions prevailing in all the aforesaid Hospitals. Despite recognition of right of medical care and treatment as Fundamental Right and part of Article 21 of Constitution, the way in which the same is being cared and maintained by State is really shocking and disturbing.
94. When this matter was again taken up on 20.12.2017, we received an affidavit sworn by Dr. S.P. Singh, Principal, Moti Lal Nehru Medical College, Allahabad stating therein that two Advocate Commissioners visited Hospital of Medical College, Allahabad on 06.12.2017 and submitted their report. Meeting the facts stated in said report, in reply thereto, affidavit of Principal, in paras 6 to 25 reads as under:
- "6. That, the Advocates Commission's report has reported certain facts and after perusal of the same, it is evident that certain improvements are required to be made with regard to the facilities to be given to the inmates of the hospitals affiliated with the Medical College, Allahabad. The deponent being the Principal of the Moti Lal Nehru Medical College, Allahabad would make all possible efforts to improve the services required to be given to the inmates of the hospitals affiliated with the Medical College, Allahabad.
 7. That, what regard to paragraph-1 of the Advocates Commission report, it is submitted that civil work of Trauma Centre has been completed, lift and gas pipe lines have also been completed. Although in the OT and post operative areas are fitted with AC's in the interest of patients, and for proper management of the patients in remaining area, a demand Rs.364.01 Lakhs has been sent to the Urban Development Department through the District Magistrate, Allahabad and Principal Secretary, Medical Education, Government of U.P. Lucknow on 22.09.2017 for installing AC's and power connection. True photocopy of the letter dated 22.09.2017 is being annexed herewith and marked as Annexure No.1 to this affidavit.
- It is further submitted that a reminder letter was again sent through the District Magistrate, Allahabad on 08.12.2017 and the Principal Secretary Medical Education, Government of U.P. regarding the aforesaid demand to the Principal Secretary, Urban Development Department, Government of U.P. regarding the said demand. It is further to be added

that the Special Secretary, Medical Education, Government of U.P. vide his letter dated 09.12.2017 recommended the release of the proposed amount of Rs.364.01 Lakhs for AC and power connection in trauma centre in one installment itself in the Financial Year 2017-18. True photocopies of the letters dated 08.12.2017 and 09.12.2017 are being annexed herewith and marked as Annexure No.2&3 to this affidavit.

8. That, with regard to paragraph-2 of the Advocates Commission Report, it is submitted that trauma patients are treated separately in the separate building. The Machines are stored in store room because the operation theater is under repair to transform as modular OT. The medical equipments/machines are installed in year 2010-11 and all of them are functional. The few equipments are kept in OT store room and rest are used in the surgical ICU and OT-5 where the trauma cases are operated. Details of the patients treated in trauma building is being annexed herewith and marked as Annexure No.4 to this affidavit.
9. That, with regard to paragraph-3 of the Advocates Commission report, it is submitted that the emergency room is only a resuscitation room. The patients are examined and classified according to severity of disease and triage system and there are six beds and out of six beds, five beds have the facility of oxygen pipeline system. From there the patient then transferred to presently running three trauma wards, HDU and surgical ICU's for proper treatment.
10. That, in regard to paragraph-4 of the Advocates Commission report, it is submitted that the patients are attended at once as they reached the respective wards. There could be some delay in case there is huge rush of patients and that process is quite natural.
11. That, in regard to paragraph-5 of the Advocates Commission report, it is submitted that the proposal for renovation of existing emergency wards (orthopedics, surgical male and female wards) an amount Rs.386 Lakh has been demanded from the State Government vide letter dated 22.09.2017, which has already been annexed as Annexure No.1 to this affidavit.
12. That, in regard to paragraph-6 of the Advocates Commission report, it is submitted that the proposal of construction of new waiting hall and six additional registration counters amounting to Rs.70.15 Lakh has already been sent to State Government vide letter dated 22.09.2017. However, the report itself makes it clear that there are five counters operating for the purposes of registration of the patients and it is because of the huge rush, there are further requirement of additional counters, for which request has already been made from the State Government vide letter dated 22.09.2017, annexed as Annexure No.1 to this affidavit.
13. That, in regard to paragraph-7 and 8 of the Advocates Commission report, it is submitted that the M.R.I. and C.T. Scan Machines are functional. The demand for creation of the post of Technicians for M.R.I. And C.T. Scan has already been sent to the Director General, Medical Education & Training, U.P. Lucknow vide letter dated 18.07.2017. True photocopy of the letter dated 18.07.2017 is being annexed herewith and marked as Annexure No.5 to this affidavit.

14. That, in regard to paragraph-9 of the Advocates Commission report, it is submitted that few patients come to the hospital after being referred from private nursing home and various CHCs. These patients have their M.R.I./C.T. already done in their previous admitted places. The details of M.R.I. And C.T. conducted at SRN Hospital is placed on record in the form of a chart dated 05.12.2017, which is being annexed herewith and marked as Annexure No.6 to this affidavit.
15. That, in regard to paragraph-10 of the Advocates Commission report, it is submitted that some private ambulances come in to the hospital alongwith the patients and they remain standing in the hospital on the request of the patients. No staff refers patients to Private Diagnostic Centre. However, vide letters date 28.11.2017 and 06.04.2017 the Senior Superintendent of Police, Allahabad and Chauki-Incharge, SRN Hospital have been requested to take action against the erring ambulances as well as vendors operative in hospitals premises. The true photocopies of the letters dated 06.04.2017 and 28.11.2017 are being collectively annexed herewith and marked as Annexure No.7 to this Affidavit.
19. That, in regard to paragraph-11 and 12 of the Advocates Commission report, it is submitted that the cardiology ICU was extended from 6 bedded to 18 bedded. The facility of ventilator and monitors is available on 6 beds. The demand of additional ventilator and monitors has already been made from the State Government. The ICUs are usually have closed windows and ventilated with Acs. The Acs are used as and when required because the cardiac patients are very prone to cold. The proposal of Rs.19.89 Lakhs for strengthening the ACs of ICU cardiology is sent with proposal dated 22.09.2017, annexed as Annexure No.1 to this affidavit.
20. That, in regard to paragraph-13 and 14 of the Advocates Commission report, it is submitted that the demand to create the post of Safai Karmachari and Ward Boys has been sent to the State Government. It is to be clarified that cleanliness is done in second shift also. It is also to be submitted that 26 post of Class III & IV is already sanctioned on 11.01.2016. The true photocopy of the Government Order dated 11.01.2016 is being annexed herewith and marked as Annexure No.8 to this affidavit.
21. That, in regard to paragraph-15(a) of the Advocates Commission report, it is submitted that the Superintendent-in-Chief, Medical College, Allahabad made request to Nagar Nigam for solid waste management at selected places and also catching the stray animals. The Principal also directed to the resident of campus to remove the live stock kept by them True photocopies of the letters dated 09.06.2016, 13.07.2016, 28.07.2016, 01.09.2015, 28.09.2015 and 06.04.2017 are being collectively annexed herewith and marked as Annexure No.9 to this affidavit.
22. That, in regard to paragraph-15(b & c) of the Advocates Commission report, it is submitted that the Superintendent-in-Chief, Medical College, Allahabad by means of his letter dated 06.04.2017 requested the Chauki Incharge to take action against.

23. The unauthorized vendors. True photocopy of letter No. 939 dated 28.07.2016 is being annexed herewith and marked as Annexure No.10 to this affidavit.
24. That, in regard to paragraph-15(d) of the Advocates Commission report, it is submitted that the preference has to be given to the young Doctors for the allotment of flats inside the campus, which is done by the District Magistrate. The deponent would emphasize the need of the young doctors to the District Magistrate and would try to ensure that demands of the young doctors be attended in order to allot the residential premises within the campus to improve the quality of the medical services to the patients of the hospitals affiliated to the Medical College, Allahabad.
25. That, in regard to paragraph-15(e) of the Advocates Commission report, it is submitted that the demand to private security personal has been sent to the Director General, Medical Education & Training, U.P. , on 29.05.2017. True photocopy of the letter dated 29.05.2017 alongwith other paramedical staff is being annexed herewith and marked as Annexure No.11 to this affidavit. "
95. Principal in his affidavit has tried to explain certain facts stated in Commissioners' Report and in respect of some aspects also tried to dispute correctness of facts stated in the Report.
96. PSME in Para 11 of his affidavit stated that Trauma Centres are in working condition in Medical College, Allahabad for the last 3-4 years while Commission found it in the process of completion as even civil work was incomplete. Principal also admits this fact but then has sought to explain that Trauma Patients are being attended in Emergency Wards and the same is being treated as Trauma Centres. We find it difficult that the Principal does not understand difference between "Trauma Centre" and "Emergency Ward". An emergency care control attends patients.
97. However, the facilities needed to run a Trauma Centre are not available in a routine emergency ward. It shows something fishy in the matter and needs investigation an enquiry. When we pointed out this discrepancy and state of affairs to learned Additional Advocate General Sri M.C. Chaturvedi, he said that there is some confusion in the matter. This led us to send another Advocate Commissioner to get photograph of building of Trauma Centres and submit report. We passed following order on 20.12.2017:
- "1. An affidavit has been filed, which is sworn by Principal of Medical College, Allahabad. It shows that the Trauma Centre Building is still in process of construction and completion but simultaneously, it also shows that thousands of patients are being given treatment in the Trauma Centre, since 2011.
 2. When we asked a specific question to Shri P.K. Pandey, learned Chief Standing Counsel, he was not in a clear position to tell us about actual position of Trauma Centre Building and its functioning.
 3. On his request, we appoint Shri Anil Kumar Jaiswal, Advocate (Roll No. 10033/12), as an Advocate Commissioner, to visit S.R.N. Hospital, attached to Medical Collage, Allahabad,

accompanying Shri P.K. Pandey, learned Chief Standing Counsel, today itself, in day's time and submit report by tomorrow.

4. Put up tomorrow, i.e., 21.12.2017. "

98. Sri Anil Kumar Jaiswal Advocate visited Trauma Centre at Swaroop Rani Nehru Hospital attached with Medical College at Allahabad and also Emergency Ward and submitted report. Para 2 of report said as under:

"(a) That Trauma Centre building lock had been opened before the Advocate Commissioner on 20.12.2017.

(b) That two story Trauma Centre building is complete.

(c) That electric wiring is completed but there is no electric connection.

(d) That A.C. is planted only in O.T.

(e) That the oxygen pipe is completed.

(f) That beds, chairs, tables or any kind of furniture have not been seen by the advocate commissioner in the Trauma Centre building.

(g) That the Trauma Centre building has not been found in functioning position on 20.12.2017.

(h) That the emergency ward of S.R.N. Hospital is being run in the name of Trauma and emergency service." (emphasis added)

99. He has also placed on record a number of photographs. A glance at photographs indicates that the Trauma Care building is without proper maintenance and cloths, undergarments etc. of some individuals were spread for drying, showing that some individuals are using the rooms as their residence.

100. In the aforesaid backdrop, arguments of learned counsel for petitioner, we find, basically are that Medical Health Care in State of U.P. is in pitiable condition. Despite constitutional obligation on the State to provide affordable quality medical care to its citizens, in particular, to poor people, same is not actually being so provided. Condition of Government Hospitals is pitiable, behaviour of Medical Staff is rude. In fact, hospitals are mostly suffering shortage of staff. There is lack of proper attention and attendance to poor patients. Free medicines to poor people, though highly canvassed in various advertisements, but ground level reality is totally different. Mostly medicines are not available. Quality of medicines is also poor. In-genuine expiry date medicines many times are supplied. Whatever funds received for betterment of infrastructure or its maintenance, mostly either siphoned off by persons responsible for maintenance or remain underutilized. There is no system of check or cross-check or deterrent action against erring officials. Even Medical Centres of emergent nature like, Trauma Centres are not maintained properly. Corruption is prevalent all through. In a nutshell, Medical Health Services maintained by State provides bitterest experience to needy ones. It is almost on ventilator and needs strong curative steps.

101. Learned Additional Advocate General Sri M.C. Chaturvedi as well as learned Chief Standing Counsel appearing for respondents stated that whatever condition is of medical services in the State, facts and figures have been placed before Court and they are not treating this litigation as adversarial proceedings but remedial and ready to accept all sorts of constructive proposals for betterment of medical service and would make all out efforts to carry them out.
102. The facts narrated above broadly can be placed in two categories. Firstly, Trauma being faced by poor patients when they attend medical services provided by State; and, secondly, emboldened, recklessness and carelessness in discharge of duty and siphoning of funds or non utilization thereof in the hands of authorities who are responsible for maintaining public health services so as to deprive poor beneficiaries from the benefit for which funds are allocated.
103. In the first category, facts disclosed by petitioners and the two Secretaries in their affidavits, bring in following deformities in the system:
 - (A) Poor attendance in medical services-
 - (i) When she visited Purkaji PHC, no Medical Officer was there and delivery was conducted only by ANM.
 - (ii) Hole in the bladder i.e. Urethra-Vaginal Fistula detected in private hospital and treatment thereof at SMC, Meerut as also KGMU, Meerut took more than six months.
 - (B) Lack of infrastructure caused delay in treatment inasmuch as at KGMU it took four months for her to get a bed available and underwent operation on 5.02.2008.
 - (C) Corruption: ANM demanded money at Purkaji, PHC; Deputy Chief Medical Officer pressurized petitioner-1 to give in writing that she had not gone for instrumental delivery and at SMC for treatment and operation again money was demanded by a junior Doctor. Fact remains that even in SMC she was not given treatment at all. At KGMU also she was administered treatment with the intervention of NGO's like Health Watch Forum and Hamsaffar.
 - (D) Deficiencies: Facts and figures disclosed by the two Secretaries with regard to Public Health Service in State of U.P. broadly shows following deficiencies:
 - (i) Poor infrastructure;
 - (ii) Short of staff;
 - (iii) Short of funds
 - (iv) Under-utilization of funds;
 - (v) Lack of will to serve people.
 - (iv) Unaccountability and apathy.

104. It is high time that State must understand that sickness, injury or accident, do not give a prior notice. Death does not wait. With the loss of time, every moment somebody and some families are losing their beloved ones. Some injuries are resulting in permanent disability. The subject of medical care needs an urgent and immediate step else there will be a permanent loss to many.
105. State of U.P. caters to maximum number of people having largest population in the country. Maximum population resides in rural area. Health care infrastructure in rural areas, as per scheme of Government of India, was developed as a three-tier system. In plain area, over a population of 5000, a Sub-Centre was to be constituted; for a population of 30000 a Primary Health Centre (PHC) was to be constituted and for a population of 120000, a Community Health Centre (CHC) was proposed. A Sub-centre is most peripheral and a contact point between Primary Health Care System and Community. Sub-Centres were assigned task relating to personal communication with the object to bring about behavioral change and provide service in relation to maternal and child health, family welfare, nutrition, immunization, diarrhea and control of communicable disease programme. Each Sub Centre is supposed to be manned at least by one Auxiliary Nurse Midwife (ANM)/Family Health Worker and one Male Health Worker. For supervision of six Sub Centres one Lady Health Visitor is supposed to be appointed.
106. PHC is the first contact point between village community and the Medical Officer. PHCs were envisaged to provide an integrated curative and preventive health care to rural population with emphasis on preventive and promotive aspects of health care. PHCs are established and maintained by State Governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services (BMS) Programme. A PHC is supposed to be manned by a Medical Officer, supported by 14 paramedical and other staff. It acts as a Referral unit for 6 Sub Centres and must have 4-6 beds for patients. Activities of PHC involve curative, preventive, promotive and Family Welfare Services.
107. CHCs are also established and maintained by State Government under MNP/BMS programme. A CHC is required to be manned by four Medical Specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician, supported by 21 paramedical and other staff. One CHC must have 30 in-door beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a Referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations.
108. Then comes higher structures like, Sub-Divisional Hospitals and District hospitals. As per norms set by Indian Public Health Standard, Primary Health Care infrastructure in the State of U.P. is highly deficient. Broadly, more than 31000 Sub Centres, 5100 and odd PHCs and about 1300 CHCs are required as per Health Care demand of State's population. According to Rural Health Statistics, 2015 data, State of U.P. is short of 33% of Sub-Centres/PHCs and 40% CHCs. Aforesaid report also shows that in the last more than a decade and half, there

has been no expansion of Health Care Institutions in the State. Entire population is tasting an experience of poor quality public health service in the State and attempting to thrive upon low quality private health care service. Private health care system includes unqualified, un-recognized Doctors and quacks who serve almost 85% of medical needs as per April 2016 "Health In India Report", published by Ministry of Statistics.

109. Various status reports published show that plan of Rural Health Care System is well conceived but ground level reality is virtually reverse in State of U.P. PHCs and Sub Centres either do not exist or if exist, are severely understaffed under-supplied. Rural Health Statistics published by Government for the year 2016, broadly show 85% shortage of Specialists, 77% shortage of Lab Technicians and 89% shortage of Radiographers in CHCs in U.P. It further shows that 91% of PHCs did not have a Lady Doctor on duty and 60% do not have functional operation theaters. Most PHCs and CHCs do not have regular supply of medicines and drugs even for common ailments.
110. We are told that most CHCs and PHCs have been provided infrastructure by structure and building only but in our view, a Health Care System is not about real estate and construction alone, its life is the persons managing real estate by providing real medical service to needy ones. If one has to provide a quality of health infrastructure, one has to go for proper staffing of Doctors, Nurses, Technicians and also requisite equipments/apparatus and regular supply of medicines and drugs.
111. It is a common case of parties that Rural people are the biggest sufferers in the matter of medical facilities and appropriate health care infrastructure. It is largely inadequate and problem is very acute. Despite the fact that rural people are primarily depending on Government Medical Health Care service, unfortunately, non-availability of medical staff and virtual total lack of advanced medical equipments to treat emergency/complicated surgical cases is nothing but a destiny in trauma for poor rural people of the State.
112. Moreover, for various other reasons, like local political interference, lack of security, frustration of not providing proper service due to inadequate instruments and apparatus, medicines etc., whatever staff is available, mostly remain unauthorizedly absent. Medical Services and patients are looked after by ill trained medical personnel, taking advantage of large illiterate population in rural areas.
113. It is also an interesting fact that Department of Medical Health and Family Welfare has a history of almost of 100 years, having been set up in 1921 through Provincial Medical and Health Services responsible for providing health related services even in remotest rural areas in densely populated State of U.P. and though sanctioned strength of doctors has increased with population, but not as per requirement. Whatever is the sanctioned strength available, that too remains mostly unoccupied for shortage of Medical officers. We are told that recruitment efforts have been made in recent past but actual appointees are very less since most Doctors, even if selected, choose not to join.

114. Recently, a news item was published that 32 cataract patients were operated using a torch light for want of electric supply at a State run Medical Care Centre at Unnao in the State of U.P. These operations were done at CHC, Nawabganj. This news was widely published in print and electronic media. Another news item was published on 25.12.2017 that ambulances in Meerut at State Medical College i.e. Lala Lajpat Rai Medical College, Meerut were used to ferry liquor. We are also aware of tragic incident at State Medical College, Gorakhpur where more than 30 children lost their lives, allegedly, for non-supply/disruption of oxygen supply. Incidents are innumerable. Common thread to all incidents is that sufferers are poor rural public and their kith and kins.
115. In order to judge standard of Medical Care Centres, in our view, a reply to simple question should be the test, "whether, if we need medical care, would prefer to go to Medical Health Centre maintained by State or a Private one".
116. When questioned in open Court, even learned State Law Officers did not immediately reply opting for State Medical Care Centres and kept conspicuous silence. Hesitatingly, they suggested that emergency requirement, if any, may have to be attended in nearest medical care establishment maintained by State Government but normally they prefer private ones. This is what is being followed by Senior Government Officials, Political Bureaucrats, People's Representatives, Members of Judiciary etc., who are resourceful enough to avail medical services maintained by private sector and most of them get appropriate reimbursement from State Exchequer. Poor, inadequate and understaffed state medical services therefore, remain to be utilized by the poor rural folk and they are ultimate victims of lack of quality in such services.
117. Above discussion, we find, is also fortified from the facts which we have in this matter and some are noticed from Commissioner's reports, as under:
- A. Deficiency of Beds and para medical Staff in S.R.N. Hospital attached to State Medical Colelge, Allahabad: Number of beds from 1961 to 2017 has been increased from 300 to 1200 but sanctioned strength of ward boys which was 104 in 1961 has remain unchanged. There was no disposal of Medical waste.
- B. Condition of Emergency Ward:
- (i) Advocate Commissioner had stated that it was very difficult to breath over there by a normal man. What would have been happening to patients is easily understandable. Emergency ward had no air conditioners, windows were blocked by fixed glass leaving no scope for any fresh air or any cross ventilation.
- (ii) The plight of patients has also been noticed stating that one patient, brought from ICU, was repeatedly requesting for being shifted back to ICU or to any other place.
- (iii) Only one MRI machine was found working having backlog of 20 days. Technicians

to run MRI Machines are not available.

- (iv) C.T. Scan machine when checked was found that it was not of Medical College but had come from outside meaning thereby it was a private machine. Patients were compelled to have C.T. Scan by permitting Outsiders to bring C.T. Scan machines at aforesaid Hospital of Medical College.
- (v) The scam of sending patients to private Hospitals has also been noticed by Advocate Commissioners' for C.T. Scan and MRI at private centres.

C. Lack of Maintenance:

- (i) There were many stray animals roaming around the campus, unauthorized vendors of fruits, tea, samosas etc.
- (ii) None availability of residential facilities to young doctors compelling them to stay at distant places from Hospital causing none availability at all times and no otherwise protection is available to patients.
- (iii) In Cardio ICU 18 beds were inside the room and 22 beds outside. There were only 2 ventilators and 5/6 monitors were operational. Room condition of Cardio ICU has also been found very pathetic and suffocating.

D. Incorrect Information about Trauma Centre at State Medical College and also disclosed poor working and maintenance condition of Hospitals at Allahabad:

- (i) Advocate Commissioners Report shows that Trauma Centre building was still incomplete. Principal, Medical College, Allahabad informed that it will take at least two months of rapid work for completion only after he receive funds sought by him from State Government in this regard.
 - (ii) Machines and equipment from Trauma Centre were already purchased and kept in operation room of Operation Theater which was also under repair. What could have been present condition of machines is easily understandable.
 - (iii) Emergency wards are being used as partial Trauma Centre and there also condition is pathetic. In 6 beds of emergency room oxygen equipment was connected in only 2 beds. General condition of emergency room was also found pathetic. Patients admitted in emergency room are not attended in time and there is a lot of delay. Emergency ward is said to be in horrible condition.
- (E) Unutilized Funds: The Affidavit filed by Secretaries shows that thousands Crores of Rupees allocated for health services remain unspent. Huge number of vacancies of Medical Officer, Para Medical Staff etc. are existing. In the sample inspection of Swaroop Rani Medical Hospital attached to Moti Lal Nehru Medical College, Allahabad, discrepancies/irregularities are noted that Trauma Centre on the one hand said to be in working condition, while Principal himself disclosed that

only civil work has completed and he has demanded further funds for making it functional. Gas Connection, electricity connection all are yet to be completed.

118. These are some deficiencies which were admitted by Principal and staff of College. With regard to other Hospitals also situation, noted by Advocate Commissioners depicts a very grim picture.
119. State of U.P. Presently having a population of about 22.3 Crores (19,95,81,477 Crores according to Census Report, 2011) is being looked after by just 174 District Hospitals whereas there are 75 Districts. These 174 Hospitals include General Hospitals, Specialized Hospitals, Hospitals maintained for women etc. Number of Tehsils, Blocks as also Gram Panchayats in State of U.P. are 316, 822, 59163 respectively whereagainst number of CHC is 821 and PHC is 3496 only.
120. For every 10,000 residents in the State of U.P. only 1 bed is available. 40% to 60% vacancies of Medical and Para Medical Staff exist. Even funds allocated are not being utilized and substantial amount remains unspent. Nobody bothers, why such a situation is persisting. Authorities are totally keeping eyes shut to the harsh fact that people of this State living under very poor and unhygienic conditions, get their plight aggravated due to lack of adequate medical services.
121. Number of these Medical Care Centers apparently is highly inadequate and shows that no serious attempt has been made by State Government in the last more than 70 years of our independence to provide effective and adequate medical services to residents of this State.
122. Advocate Commissioners' Report was only a sample fact collection exercise with regard to ground level situation prevailing committee in respect of Medical Services maintained by State of U.P.
123. The upshot is that conditions of public health care system is highly deplorable, very pathetic and pitiable. Not only hospitals maintained by Government through provincial medical services but even hospitals attached to medical educational institutions are mostly in very bad conditions.
124. In regard to serious trauma patients, though almost two decades have passed for special maintenance of Medical services for them, but situation has not improved considerably . It has further worsened due to attempt on the part of Medical officers in State of U.P. who are mostly engaged in private practice or encourage private institutions to be attended by patients, visiting State maintained medical services, which proves heavy on the pockets of patients but causing personal benefits to Government Medical Officers. Learned counsel for petitioner stated that across the State most of Government Medical Officers including Teachers in State Medical Colleges are engaged in private practice. Though Rules have been made prohibiting private practice and in lieu thereof, special non-practicing allowance of lucrative amount is being paid to all such Medical Officers, but most of them are violating these Rules with impunity. Taking advantage of worse condition of Government maintained hospitals etc.,

patients are driven to private hospitals and clinics and/or directed to attend Medical officers privately, leaving no option otherwise to ailing patients and his attendants but to act according to directions of Medical officers and thereby spend huge amount in treatment in private. On many occasions, this situation has also resulted in serious altercations and disputes between patients and their attendants on one hand and Medical and Para Medical Staff on the other, causing sometime damage to public property also.

125. Learned counsel for petitioner at this stage also stated at the Bar that Medical Officers mostly whether in Provincial Medical Service or in Medical Colleges, largely in private practice and in furtherance thereof also encourage private diagnostic and pathological tests. This is fortified from the report of Advocate Commissioner in the context of C.T. Scan found at Hospital attached with Medical College at Allahabad. Explanation furnished by Principal in the entirety of backdrop of facts stated in the two Commissioners' report in our view, is difficult to accept.
126. Report of Advocate Commissioner also points out with regard to private operators for C.T. Scan and explanation given by Principal of State Medical College, Allahabad is nothing but a lame excuse and in fact, supports the submission advanced on behalf of petitioner about private practice largely prevailing amongst officials of State Medical Services in violation of statutory Rules. This needs an in-depth inquiry into the matter.
127. On the issue of Trauma Centre at Allahabad Medical College, contradictory claims have come forth. As per two Advocate Commissioners report, Trauma Centre at Allahabad Medical College is yet to commence its function. P.S.M.E. has stated that Trauma Centre at Allahabad is functional for the last 3-4 years while Principal in para 7 of his own affidavit admits that only civil work has completed and Government has been written to sanction funds for installing AC's and power connection and these facts show that Trauma Centre is yet to take a long time for becoming functional. Therefore Affidavits of Principal Secretary and Principal, Medical College, Allahabad are apparently false. We find it strange that they have not care of verifying facts before filing affidavits in Court in such a serious matter. This shows lack of sincerity of these officers in looking into the matter relating to Public Health Services.
128. We also find it surprising that while Trauma Centre at Hospital attached to Medical College at Allahabad was under construction, which has continued even when we heard this matter and reserved judgments. Machines and apparatus for Trauma Centres were purchase long back. Since they could not have been installed at all for want of place, same have been kept in a store room by converting operation theatre which is also under repairs. What was so hurry for purchasing machines and apparatus when even building was not constructed, is beyond our comprehension. During this long period, warranty of machines must have expired and this undue hurry, in fact, points out to some undue advantage for which, these machines and apparatus have been purchased and smells lack of bona fide on the part of persons indulged in process of purchase. Principal has tried to explain that these machines are taken out whenever

needed but when Trauma Centre itself for which these machines were purchased is in the process of construction and basic amenities like electricity etc. have not been provided, where was the occasion to use these machines. It is not the case of respondents that Emergency Ward which was already operational and functional in Medical College, Allahabad had been installed with some additional machines. At least no such explanation has come forward. Moreover, machines and apparatus especially purchased for Trauma Centre, a concept introduced by Government of India, for which funds have been made available, how these machines could have been installed and used elsewhere.

129. We, therefore, have no manner of doubt that in purchase of machines/apparatus when building was not ready, there was something grossly illegal and corruptible, which needs an in-depth audit and inspection in the hands of experts of appropriate agency.
130. The 'Emergency' of hospital which presently is being also used as partial Trauma Center hardly satisfies the guidelines meant for a Trauma Centre. A separate stand alone building is needed, civil work whereof, as reported by Advocate Commissioner, will take sometimes. We are informed that construction started about 6-7 years back but machines and other equipments were purchased long back. Since same were not to be used as building itself was not constructed, they were stored in a badly managed OT room. With the passage of time, condition of such apparatus and instruments can be well imagined and we have to keep our fingers cross as to how many instruments now would be in a working condition. Despite our query, learned Standing Counsel could not explain need of purchase of all instruments when building itself was not constructed. It appears that some were interested only in purchases unconcerned as to what will happen to those items with passage of time. For loss of items and instruments due to being idle, those persons who have purchased same are directly responsible. More we discuss the matter, more we find disturbing inferences and conclusions.
131. In the context of trauma patients we are also informed by learned counsel for petitioner that many deaths of trauma patients, take place due to hurdles in transportation of these patients to Medical Care Centre. Ambulances do not get clear passage for various reasons and people die on the way during transportation. On this aspect also, we have been addressed by both sides at length and this aspect needs serious attention on the part of State so that vehicles carrying patients do not face any traffic congestion and get clear road to reach destination without wasting time. It is a common case of both parties that quick transportation of injured and serious patients to hospitals for immediate treatment is obstructed due to huge traffic on roads. With respect to non-clearance of ambulances and lack of awareness of public to make way for unobstructed passage of ambulances, there is a complete traffic mismanagement on the part of authorities responsible for this purpose.
132. We are informed that even in normal day to day affairs, due to huge increase in auto-vehicular traffic, roads are almost packed, people drive vehicles lack basic training of providing access to ambulances, park their vehicles on the roadside or ways and cause jam like situation at

different places. Most of the time, patient suffers for the reason of delay in speedy availability of treatment at the first instance. Learned Advocate General, representing respondents State of U.P. and its authorities, on this aspect, joined the issue with counsel for petitioner and submitted that despite best efforts by local authorities managing traffic, it is very difficult to avoid congestion and jams. Many times it causes obstruction in free passage of ambulances, ultimately causing loss to injured/serious patients.

133. This is a serious matter. We find no reason that it should not immediately be attended. Court can take judicial notice of the fact that in the past complaints of detention of ambulances in restricted traffic movement due to visit of high dignitaries and VIPs sometimes proved fatal to serious patients in detained ambulances.
134. In the last few years, due to sudden spurt in four and two wheelers on roads, traffic congestion has become a routine affair and many times it results in jams. Many a times road traffic get jammed because of haphazard movement of traffic in indisciplined manner obstructing both ways traffic and sometimes on account of indiscreet, uncontrolled and arbitrary parking of vehicles aggravated by encroachment on roads and sideways. This situation requires immediate remedial measures atleast to protect the life of injured/serious patients by allowing unobstructed smooth passage to ambulances carrying patients.
135. Learned Additional Advocate General when asked to suggest steps on his own, could not give effective reply but stated that State shall make all out efforts and will turn every stone to carry out directions of Court in order to provide best medical services to Upians.
136. Thus question left open to the Court to decide is nothing but an herculean task of finding out appropriate solution so as to mitigate plight of poor rural people of State in the matter of medical care which is their fundamental right being part of Article 21 of Constitution. A million dollar question is how and in what manner ? It needs indepth study of the matter.
137. In our view, foremost apathy and lack of serious endeavour and attention on the part of higher authorities for not providing quality medical service is for the reason that they themselves are not affected at all. For them, State Medical Services, in particular, rural health service programmes are meant only for poor rural class. They belong to different class. It is a class discrimination which is not allowing the system to improve in the last several decades.
138. We can take judicial notice of the fact that development of Clinics, Hospitals and Nursing Homes in private sectors is multifold and very fast. Some of private sector establishment in medical treatment are providing worlds class service and people are travelling to India on medical tour for treatment of their serious ailments. The cost of medical treatment in such private sectors in India, we are informed, is cheaper than what it is available at abroad. Number of sophisticated private Nursing Homes, Hospitals and medical constitutions have been established providing medical services at a cost which from the standards of common man of this country is beyond dreams. At least rural people who constitute largest population of this country find it impossible to avail such facility. That is why, these hospitals and Nursing

Homes cater to need of Society's upper class who can afford the same. Learned counsel for petitioner also submitted and we find substance therein that resourceful, powerful and rich people do not bother to avail medical services run by State. Their care is taken by Private Medical Practitioners, Hospitals and Nursing Homes. They are the lots who are financially sound, powerful enough and enjoy strong clout to avail best medical services since they are not bothered for funds needed for the same. It is only poor rural and urban people, who are left at the mercy of inadequately and poorly maintained State run Medical Services and fall victim to such worst services, losing there lives like ginny pigs. Death of such person in the eyes of State appears to be mere statistic. Authorities are so heartless and apathetic that they do not seriously look into needs and requirements of these services for better attendance to beneficiaries.

139. So far as basic principle of State's constitutional obligation to maintain public health services to its residents is concerned, it is not disputed even by learned Standing Counsel. The problem lies in the manner services are being maintained by State and other stakeholders responsible for its maintenance and operation. Huge utilization of funds, large number of vacancies, apathy on the part of staff, wide spread corruption, lack of supervision and monitoring, diversion of interest from public to private, i.e., engagement in private practices and to divert patients to private medical institutions, lack of infrastructure, wherefrom available misuse or unmindful purchase for reasons best known to responsible persons, are some of the apparent grave problems which are denying, in effect, appropriate, quality services to needy ones. Unfortunately, sufferers are mostly from lower rung of society since resourceful rich and powerful persons are able to avail better services for them in private hands. Government, for the reasons best known to it, turn its blind eye to this state of affairs. To some extent we find that even political executives and bureaucratic executives, both are party in taking benefit of this diversion and, therefore, a mutual trust has developed in allowing the system to run on its own, and this is causing in a parallel system. That is how in the matter of public health services it has become a twin class service.
140. Government Officials since are reimbursed medical expenses, frequently they avail better private medical services and claim reimbursement from State Exchequer. Therefore they have no reason to bother for quality of medical services run by State. Superior bureaucrats and others holding High Offices, Ministers, People's Representatives etc., as and when needed, go to avail expensive private medical services, leaving only poor people who have no capacity to avail such expensive services and left at the mercy of these Institutions run by State in the worst conditions. Moreover, High Officials frequently visit places like Lucknow, Gautam Budh Nagar etc. where Medical Institutions of Highly Specialized Services have been established which are also easily available to those who have resources or approaches. Others have no option but to wait for their turn in queue for long time and many succumb in queue, incapable of waiting for their turn. Even more powerful people, whether from Politics or from Executives etc., they avail medical services even abroad, having lessor confidence in

medical services run by State or even private, on account of situation created by themselves by not maintaining medical services through most meritorious and professional persons. These high class political executives and others who travel abroad for their treatment, when come back, again canvass, profess and apparently claim to pursue cause of backward people so as to provide them place in State Medical Services but keep themselves aloof from giving opportunity to such people to have pride of providing medical services and treatment to them. When it is a matter of life, no one can imagine to compromise in the matter of quality, merit and effectiveness but this precaution is maintained by resourceful people when it comes to their own or their family members but for common poor people it is residuary service made available by them which has to be availed in absence of any other option, may be, due to financial scarcity or otherwise.

141. In our view, any person who is entitled to medical reimbursement from State Exchequer must be asked compulsorily to avail medical services maintained by State failing which, no medical reimbursement should be allowed. This is one way whereby medical services run by the State may undergo improvement due to continuous monitoring. If highly placed officials, resourceful persons and other dignitaries, whenever needed, go for treatment to Hospitals and Medical Services maintained by State, functional conditions of these institutions, in our view, may go under a sea change towards improvement but if these services are left for have nots, such lot having no say in governance, may not be able to get any desired improvement in such services and the mere fact that such people have power to punish inactive persons over five years is nothing but something making mockery of helplessness of these people.
142. Inefficient, inadequate, improper, unclean and bad services at the level of PHC or additional PHC or above is mostly attended by poor people and they suffer all these odds. At the highest level namely medical colleges or KGMU or some specialized autonomous institution. like Sanjay Gandhi Post Graduate Institute etc., people of status sometimes also visit, but, mostly, they manage their affairs by availing medical facilities in well equipped highly sophisticated and expensive private medical institutions and mostly reimbursement is made by Government. It is for this reason that the executives, whether bureaucrat or political, both, neither have a first hand information about problems of public health service nor they care since they are not affected and those who mostly attend have no voice. They are weak, underprivileged, deprived and feel satisfied with whatever is made available to them. That is how they are also cheated, misused and exploited in the hands of scrupulous lower staff as we have seen in the present case where ANM demanded illegal gratification from petitioner-1. If in one word we have to describe State Medical Services, it is quite apt to use the word for its functioning on its destiny and fate i.e. "Ram Bharose".
143. Learned Standing Counsel sought to explain shortage of medical officers for PHCs and CHCs stating that basic amenities are not available to these medical officers in CHCs and PHCs. For example, neither requisite instruments are made available nor medicines are available nor the individual requirements are fulfilled, like residence, conveyance etc. On the top of it, there is a

serious problem of security in rural areas on account whereof medical officers are reluctant to attend duties in CHCs and PHCs. Many a times when recruitments are made, most persons selected, either do not join or if join, leave job in a short time and switch over to private medical hospitals and nursing homes. The real problem lies in a large gap of availability of medical officers and demand. What he tried to explain is the problem where various things are interconnected and for one or another, due to non-availability the ultimate sufferer is the poor beneficiary who stands deprived of appropriate service in Government run hospitals.

144. To some extent, we feel that learned Standing Counsel may be right. Deficiency of qualified staff is on account of shortage of such staff not in service but on account of non-availability. When we go deeper in the matter we find that whenever process of recruitment commenced, number of applicants for medical services is multifold than the number of posts advertised. This could not be explained by learned Standing Counsel and we find that problem lies elsewhere, may be in the system of recruitment or on account of siphoning of resources and not providing proper equipment and infrastructure like apparatus, instruments for treatment and medicines. Medical Officers finding it difficult to provide effective services, also for other options. Budgetary allocation is quite high. We could not understand huge unspent fund and reason therefor. No one is taking care to explain reason for such unspent funds when services are in such a bad shape. Moreover, wherever funds are spent, still facilities are lacking and it also needs explanation. In our view, it is a case of sheer negligence, lack of supervision and non accountability which is persisting the problem. We do not want to lengthen our judgment with voluminous observations since things are self speaking and process of improvement also needs a large scale scrutiny at various level. Much more and serious steps need be taken at different levels we need real dedicated and devoted people to be appointed to serve needy person. Remedial measures, therefore, will have to taken in phases and, therefore, matter require multifarious directions to be acted at different levels as it cannot be done in one go.
145. So far as second petition is concerned, suffice it to mention that Chief Medical Officers in Districts may be directed to ensure strict compliance of Medical Termination of Pregnancy Act, 1971 as amended by Termination of Pregnancy Amendment Act, 2008 and Medical Termination of Pregnancy Rules, 2003 and take punitive and deterrent action without fail else, they will be personally held responsible inviting criminal and civil action besides and departmental action.
146. In the light of above discussions, we find it appropriate to issue following directions to the State Government, U.P. through Chief Secretary:
- (i) Immediate steps shall be taken to fill in existing vacancies of Medical, Para Medical and other attending staff at various levels in all Hospitals maintained by State Government through Department of Medical Health and Family Welfare or Medical Education.
 - (ii) State Government would ensure appointment of competent staff by reducing existing vacancies to 50% within first four months from the date of communication of this

Judgment and remaining vacancies in the next three months.

- (iii) Necessary supply of medicines of quality to all Medical Care Centre at different levels must be ensured. Similarly availability of requisite apparatuses, instruments, operation theatres and other medical requirements as per status of Medical Care Centres be maintained and continuous maintenance should be ensured under constant monitoring by responsible persons and they should be made accountable for any laxity or deficiency in such supply and availability.
- (iv) For Medical Care of women and especially pre-natal and post natal treatment, lady Doctors and supporting lady Para Medical and Nursing Staff be recruited and their availability be maintained.
- (v) A road map/Action Plan should be prepared in consultation with all stake holders responsible for maintaining medical services by State so that quality medical treatment is available to poor people in the same manner as it is available to resourceful high officials and rich people, and people may not suffer in the matter of medical care merely on account of their poverty, illiteracy and other constraints.
- (vi) Looking to fact that in sample survey got conducted by this Court through Advocate Commissioners, demonstrating a large number of apparent mismanagement in Hospitals whether maintained by State Medical College at Allahabad or by cadre of Provincial Medical Services, Special Audit through CAG should be got conducted without any further delay. In this regard, we direct requisite number of Specialized Audit Team having expertise in audit of Medical Care Centres be constituted with request to CAG, within one month from communication of this Judgment. At first instance, Medical Colleges and Hospitals attached to them should be got audited. This audit must be completed within two months. This Special Audit must examine funds made available, their utilization etc. in the last 10 years. If deficiencies, irregularities and illegalities are found, concerned department shall also identify erring officials and would take appropriate stern action whether civil, criminal or departmental, as the case may be, without any further delay.
- (vii) After special audit of Medical Colleges and Hospitals attached to them, next Audit should be that of District level Hospitals, for which also, complete exercise would be done within two months and it shall be adhered to. In third phase such Special Audits will take care of next lower level Medical Care Centres i.e. CHCs and PHCs.
- (viii) Entire Audit exercise of all levels shall be completed within a year.
- (ix) We may also mention that above Special Audits shall include an investigation relating to funds made available and expenditure etc. on Trauma Centres also wherever they have been proposed or are functional or under construction.
- (x) Director General, Vigilance shall constitute special teams at District level to find out Medical Officers of State Government who are engaged in private practice or running

Hospitals, Nursing Homes or attending or providing treatment to patients in such private Hospitals etc. Said teams shall also investigate into cases of radio diagnosis and pathology test from private institutions and establishments, in respect of patients who are under treatment at State Medical Care Centres. Team shall find out reasons for non conduct of Radio Diagnostic or pathological services by institutions run by Government. Wherever private Radio Diagnosis and pathology tests are found got conducted from private hands, encouraged by Government Medical Staff, appropriate action including criminal and departmental shall be taken against them. We direct competent authority in such matters to proceed with such report of vigilance and take appropriate action at the earliest. Aforesaid vigilance teams, wherever finds Government Medical Officers/ officials indulging in private practice, may also register First Information Report against them. Besides, competent authority in the State Government shall take appropriate stern action without any further delay besides recovery of entire non-practising allowances paid to such violators.

- (xi) It shall also be ensured that all Government Officials and others who receive salary or other financial gains from Government/Public exchequer, should avail Medical Care services from Hospitals run and maintained by Government and whenever any High level officials, political Executives or other dignitaries go for treatment, Medical Officer on duty, by roster, shall attend him and there shall be no special VIP treatment. If medical care is obtained in Private Hospital etc. Government must not reimburse the same. However, if there are some kinds of diseases or ailment, treatment /cure whereof is not available in Government Hospitals, and for that purpose, treatment in private becomes necessary, this condition may be relaxed but in such contingency, Government must ensure that for similar ailments and deceases if suffered by common poor people, arrangement should be made for their treatment also at Government expenses in such Private Medical Care Institutions.
- (xii) With respect to malpractices and irregularities found in sample survey of Hospitals attached to Moti Lal Nehru Medical College, Allahabad, we recommend Special Vigilance Enquiry in the matter as also a separate Special Audit of CAG, to be conducted immediately. Vigilance enquiry shall be conducted by a team constituted by Director General, Vigilance. Aforesaid special vigilance team if finds defalcation of funds etc., appropriate criminal action would be taken besides recommending disciplinary action against erring officials, whereupon, competent authority shall take appropriate disciplinary action.
- (xiii) In the matter of appropriate treatment at Trauma Centres, State Government shall ensure transportation of patients to Trauma Centres. One of important step which needs immediate care is that unobstructed smooth passage be made available to ambulances carrying such patients. This aspect needs effective Traffic Management on roads and other requisite preparation. On this aspect we issue specifically following directions to

Principal Secretary Home; Transportation as also Director General of Police, U.P.:

- (a) Immediate instructions be issued to all Traffic Police Personnel in the State to canvass and spread public awareness about regulated parking of vehicles at places meant for same, non parking of vehicles on roads and sideways, removal of encroachment of all kinds so as to make roads, sideways and service lanes clear. This awareness programme should run for a reasonable time but not so long as may frustrate the very purpose. In our view, let this programme be conducted for a period of two months.
- (b) People driving vehicles be made aware that they should not park vehicles in an indiscreet manner, obstructing free flow of traffic on road and in no case a vehicle should be parked on road side ways and service lanes.
- (c) Whenever vehicles are stopped for any reason including traffic signals, people must stop the same in a single line ensuring clear passage for ambulances and fire brigades etc. Any violation should be dealt with strictly attracting heavy fines on violators
- (d) After carrying on above Awareness Programme for two months, entire Traffic Police Force including other Police Personnel shall ensure clear passage, proper parking of vehicles, non-encroachment of roads etc. and any person violating the same should be fined heavily.
- (d) Local Traffic Police people, if any congestion is caused, should be held personally responsible and appropriate strict action be taken against them.
- (e) Any damage suffered by injured/serious patients due to obstruction in smooth passage for ambulances etc. must be held a criminal liability, besides civil, of the person(s) creating such obstruction as also the persons responsible for management of traffic including Traffic Police Personnel.
- (f) In residential areas where people park their vehicles outside their residences or in commercial areas where also people park vehicle on roads etc. due to non-availability of parking space in their residences or commercial places, responsibility shall be fixed upon the residents and persons running commercial activities without providing parking space, by imposing heavy penalty etc.
- (g) Immediate requisite provisions be made prohibiting registration of Auto vehicles unless purchaser has sufficient parking place at their private places. In other words, Government should make provision restricting purchase of new vehicles and registration thereof unless person(s) purchasing vehicle have parking place at their residences.(h) State Government shall also take immediate steps for providing dedicated corridors for movement of vehicles of essential service as an honour of fundamental right to patients and injured people to get quickest medical services

and travel on road without any obstructions and also to ensure other essential services to be carried out without obstruction. In other words, a dedicated corridor shall be prepared for movement of ambulances carrying patients which is also a part of Trauma Care Facility and even otherwise, quick movement of ambulances for timely availability of medical services is fundamental right of patients and healthy people traveling on road are also under an obligation not to create any obstruction in life saving vehicles, like ambulances and a clear passage has to be maintained at any cost.

- (xiv) Special Committees at District and Block levels be constituted on permanent basis which may have participation of common people and members of society to monitor proper functioning of Medical Care Centres of State and regular availability of requisite instruments, apparatuses, medicines etc. and also effective careful service to poor patients.
- (xv) Free food to patients and their attendants shall also be ensured in all State run Medical Care Centres so that for want of appropriate diet, poor people may not suffer while undergoing treatment.
- (xvi) Fields, lawns etc. maintained in medical colleges, hospitals attached to medical colleges and other Government hospitals shall not be allowed to be used for any celebration or function like marriage ceremony etc. If any staff of medical establishment is residing in campus, this restrain order will not apply to him but officer incharge shall ensure that musical sound and disturbances shall not be allowed beyond the prescribed level of noise and there shall be no celebration/disturbance after 10 pm. In no case any such activity shall be allowed to others.
- (xvii) In the matter of medical termination of pregnancy, we direct all Chief Medical Officers in concerned districts to ensure observance and compliance of Medical Termination of Pregnancy Act, 1971 as amended by Termination of Pregnancy Amendment Act, 2008 and Medical Termination of Pregnancy Rules, 2003. In no case any unregistered hospital or clinic shall be allowed to function. Any laxity shall be treated personal responsibility of the concerned Chief Medical Officer and he/she will be liable for appropriate action treating failure as his collusion with erring personnel.
- (xviii) State Government shall also ensure that in no case funds allocated for Medical Services remain unutilized and unspent. Where there is violation, persons responsible for non-utilisation be taken to task by taking disciplinary action against them treating it a serious misconduct for the reason that funds allocated for welfare of Medical Services, if are not spent, it means that requisite service to that extent has been denied.
- (xix) For filing false affidavit before this Court, we also issue notice to Mr. Rajneesh Dubey, Principal Secretary, Medical Education, Government of U.P., Lucknow and Dr. S.P. Singh, Principal, Medical College to show cause as to why action for filing false

affidavit before this Court, under Section 340Cr.P.C. and for Criminal Contempt under Contempt of Courts Act, 1971 be not initiated against them. Office shall issue notice and register it separately as Miscellaneous Case.

- (xx) We also make it clear wherever any authority in State Government if finds expedient, may approach this Court by filing an application for clarification/modification of this order wherever and whenever required for effective compliance of directions given above.
- (xxi) Chief Secretary, U.P. Lucknow is directed to ensure supervision and compliance,. He shall collect information from all responsible Secretaries of Departments and Heads and submit Action taken report, in first phase, within one week after expiry of six months. For perusal of such report, matter shall be listed before the Court on 25.9.2018.

147. Both the writ petitions are disposed of with the directions and in the manner as aforesaid.
148. Copy of this judgment shall forthwith be sent by Registry for information and compliance to Chief Secretary, U.P. Lucknow; Principal Secretary Medical Education; Principal Secretary, Medical, Health and Family Welfare; Principal Secretary Home, Principal secretary, Transport, Government of U.P. Lucknow and Director General of Police UP, Lucknow.

**Pooja Sharma and ANR Vs Kasturba Hospital and ORS W.P (C)
6499/2018**

*IN THE HIGH COURT OF DELHI AT NEW DELHI

+W.P.(C) 6499/2018 & CM No. 24897/2018

POOJA SHARMA AND ANR.

..... Petitioners

Through: Ms Harini Raghupathy, Advocate.

versus

KASTURBA HOSPITAL AND ORS.

..... Respondents

Through: Ms Monika Arora, Standing Counsel, North MCD with Mr Harsh Ahuja,
Advocate for R- 3/North MCD.

Mr Anil Soni, CGSC with Mr Abhinav Tyagi, Advocates for R- 5/UOI.

Ms Hetu Sethi, ASC, GNCTD with Mr Siddarth Agarwal, Advocates for
Lok Nayak Hospital with Mr Neeraj Kharbanda, Sr. Assistant, Lok Nayak
Hospital.

CORAM:

HON'BLE MR. JUSTICE VIBHU BAKHRU

O R D E R

% 22.02.2019

1. The learned counsel appearing for the petitioner seeks time to respond to the affidavit filed on behalf of respondent no.3. Insofar as her current medical needs are concerned, this Court is informed that the petitioner has been regularly availing the services at respondent no.2 hospital



(Lok Nayak Hospital). In this regard, it is clarified that respondent no.2 shall render all necessary medical aid to the petitioner free of cost.

3. Order dasti under signatures of the Court Master.

VIBHU BAKHRU, J

FEBRUARY 22, 2019 MK

Rumanchala Bhoi Vs State of Orissa and ORS W.P. (C) 20996/2018

IN THE HIGH COURT OF ORISSA, CUTTACK
 W.P. (C) No. 20996 / 2018
 Code No. 019406

In the matter of

An application under Article 226 and 227 of the Constitution of India.

And

In the matter of:

An application relating to death of Late Josada Bhoi a pregnant women due to denial of services, in-action of the state and non implementation of the welfare schemes by the department of Health and Family welfare and Women and Child Development Department.

And


In the matter of:


Ramanchal Bhoi, aged about 28 years, S/O- Rameswar Bhoi, At- Salekela, P.S- Boden, Dist- Nuapara.

....Petitioner


Versus

1. Union of India represented through its Commissioner-Cum-Secretary, Health & Family Welfare Department, Secretariat Building, Bhubaneswar, Dist- Khurda.
2. Union of India represented through its Commissioner-Cum-Secretary, Women & Child Welfare Department, New Delhi.


9/19/12-2018
Advocate
CUTTACK



Presented In Court
 12/19/18 B.O.


 2000
 A-24

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3. State of Orissa represented through its Commissioner-Cum-Secretary, Health & Family Welfare Department, Secretariat Building, Bhubaneswar, Dist- Khurda.
4. State of Orissa Commissioner- Cum- Secretary, Women & Child Welfare Department, Secretariat Building, Bhubaneswar, Dist- Khurda.
5. Mission Director, National Health Mission, Odisha Nayapalli, Bhubaneswar, Dist- Khurda.
6. Collector-Cum-Chairman, Zilla Swasthya Samiti, Nuapara, At/Po/Dist-Nuapara.
7. Chief District Medical Officer, Nuapara At/PO/Dist-Nuapara.

...Opposite Parties.



[Handwritten signature]

C.-98]

W.P.(C) NO.20996 of 2018

Sl. No. of Order	Date of Order	ORDER WITH SIGNATURE	Office note as to action (if any), taken on Order
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02. 30.04.2019

Heard.

The petitioner is stated to have filed a representation vide Annexure- 5 before the Collector-cum-Chairman, Zilla Swasthya Samiti, Nuapara-Opposite Party No.6 for redressal of his grievance. The said representation is stated to be still pending.

Taking into consideration the facts and submissions and without going into the merit of the case, the writ application is disposed of, directing the Collector-cum-Chairman, Zilla Swasthya Samiti, Nuapara-Opposite Party No.6, to dispose of the representation of the petitioner vide Annexure- 5 within a period of two months from the date of receipt of a certified copy of this Order.

The petitioner is directed to supply a copy of the writ application containing all the Annexures along with a certified copy of this Order to the Opposite Party No.6 for convenience & reference to Annexure-5.

The writ application is accordingly disposed of.

Urgent certified copy of this order be granted as per rules.



Subha

Sd/- C. R. Dash, J.

Comp. by Adm
02.05.19

• **Denial of medical Services and Discrimination to PLHIV**

Rekha Devi vs. Union of India through the Ministry of Health and Family Welfare & Others, DN: 512914/2015

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*IN THE HIGH COURT OF DELHI AT NEW DELHI
+W.P.(C) 158/2016 and CM No.15654/2017

REKHA DEVI Petitioner

Through: Ms.Sija Nair Pal, Adv. versus
MINISTRY OF HEALTH & FAMILY

WELFARE & ORS ... Respondents

Through: Mr.Sanjay Jain ASG with
Mr.Jasmeet Singh, CGSC. Shreevats and Ms.Pallavi Shali, Adv.
Mr.Peeyoosh Kalra, ASC with Mr. Shiva Sharma, Adv. for R-2 to R-6.

CORAM:

HON'BLE THE ACTING CHIEF JUSTICE
HON'BLE MR. JUSTICE C.HARI SHANKAR

O R D E R

% 25.05.2017

1. This writ petition has been filed complaining that the Anti Retroviral Treatment for the people living with HIV is not adequately available in Delhi. The respondents have filed an affidavit explaining the circumstances in which the shortage had resulted on some occasions and also

indicated the steps which have been taken to remove the same. We are assured that every steps shall be taken to ensure that no such shortage occur in future. In view thereof, the prayer made at Sl. Nos. (iii) to (viii) stands satisfied.

2. In prayer no.(i). The petitioner seeks direction to the respondent nos.1 to 4 to ensure that all the vacant post of doctors and other staff at the Anti Retroviral Treatment Centres (ART Centres) in Delhi are filled up. There can be no dispute to the fact that these posts are required to be filled up at the earliest. The respondents shall ensure that all vacant seat to the posts of doctors as well as ancillary staff in ART Centres in Delhi are filled up at the earliest.
3. A grievance is also made by the petitioner that to avail the medical facilities, for a person below the poverty line, who is HIV positive, the ART Centres are insisting of production of Aadhar Card, even though the person produces a BPL or AAY card.
4. We are informed by Mr.Sanjay Jain, learned ASG that as per the short affidavit filed by the Respondent no.4/GNCTD, the Aadhar card cannot be insisted upon and that production of any identity proof in the nature of ration card/voter card/ART treatment card can be produced for availing medical facilities. The applicants can also submit the National Food Security Card as income proof, as these cards are intended for the population living below the poverty line.
5. The respondents shall ensure that the staff at the ART Centres are informed about all these requirements and options and that no person is denied the medical facility despite production of the identification.
6. Ld. Counsel for the petitioner submits that in view of the above directions, all prayers made in the writ petition are satisfied.

Accordingly, the writ petition and application are disposed of in the above terms.

Dasti.

ACTING CHIEF JUSTICE

MAY 25, 2017

mr C.HARI SHANKAR, J

**Mr. Hxxx Vs. Lok Nayak Jai Prakash Narayan Hospital & Ors. W.P. (C)
9563/2017**

\$-69

*IN THE HIGH COURT OF DELHI AT NEW DELHI
+W.P.(C) 9563/2017 & CM Nos. 38899/2017 & 38900/2017

MR. HXXX Petitioner

Through: Ms Sija Nair Pal and Mr Deepak Kumar Singh, Advocates.

versus

LOK NAYAK JAI PRAKASH NARAYAN
HOSPITAL & ORS Respondents

Through: Mr Santosh Kumar Tripathi, ASC,

GNCTD.

CORAM:

HON'BLE MR. JUSTICE VIBHU BAKHRU

O R D E R

% 30.10.2017

1. The petitioner has filed the present petition, inter alia, seeking compensation of amount of `1.5 lacs incurred by the petitioner during his medical treatment in a private hospital. It is the petitioner's case that he was discriminated and the requisite treatment was not provided to him by respondent nos.1 & 2 hospitals.
2. The learned counsel for the respondents counters the submissions that the necessary treatment has not been provided.

3. It is seen that the present petition raises several disputed question of facts including the quantum of compensation payable, if any. This Court is of the view it would not be apposite to examine the said controversies in this petition.
4. Accordingly, the present petition is disposed of with liberty to the petitioner to file appropriate proceedings.

VIBHU BAKHRU, J

OCTOBER 30, 2017/MK

Sanjeet Singh Vs. Union of India & ANR W.P No. 2001/2018

IN THE HIGH COURT OF JUDICATURE AT PATNA

Civil Writ Jurisdiction Case No.2001 of 2018

Sanjeet Singh Son of Late Naresh Singh Resident of Hazipur Colony, Care of Ramanand Sahu, Post Office Road, P.S. - Digha, District - Patna.

... .. Petitioner

Versus

1. The Union Of India through Secretary, National AIDS Control Organization (NACO), 9th Floor, Chandralok Building, Janpath New Delhi
2. Principal Secretary, Department of Social Welfare, Bihar.
3. The Principal Secretary, Department of Social Welfare, Bihar.
4. The District Magistrate, Saran.
5. The Chief Medical Officer-cum-Civil Surgeon, Saran.
6. The Project Director, Bihar State AIDS Control Society BSACS, Sheikhpura, Patna.
7. The In-Charge, Anti Retroviral Therapy ART Centre, Chapra, Saran.
8. The Secretary, Ministry of Health and Family Welfare, Government of India, New Delhi.

... .. Respondents

Appearance :

For the Petitioner/s: Mr. Vikash Kumar Pankaj, Adv.

For the State : Mr. Ajay Bihari Sinha, GA8

Mr. Neeraj Raj, AC to GA8

For UOI: Mr. S.D.Sanjay, ASG

Ms. Punam Kumari Singh, CGC

For respondent no.6: Mr. K.K.Sinha, Adv.

Mr. Shashi Shekhar, Adv.

CORAM: HONOURABLE MR. JUSTICE JYOTI SARAN

and

HONOURABLE MR. JUSTICE ANJANI KUMAR SHARAN

ORAL ORDER

(Per: HONOURABLE MR. JUSTICE JYOTI SARAN)

3 07-05-2019 Heard Mr. Vikash Kumar Pankaj, learned counsel for the petitioner. While Mr. Ajay Bihari Sinha represents the respondents no. 2, 3, 4, 5 and 7, the Project Director, Bihar State AIDS Control Society, Patna is represented through Mr. K.K.Sinha and the Union of India in its Ministry of Health is represented by Ms. Punam Kumari Singh, learned Central Govt. Counsel.

An issue of grave Public Interest is raised in this writ petition but unfortunately it is made limited to the facility available for the HIV+ infected patient at Sadar Hospital, Chapra.

A counter affidavit is filed by respondent no.5 i.e. Chief Medical Officer on behalf of the Department as well informing that the only available CD4 machine and the Anti Retroviral Therapy Center within the Sadar Hospital, Chapra is functional and regular Pathological tests are being carried out of all such patients.

Mr. Pankaj, learned counsel appearing for the petitioner, while confirming to the affidavit submits that the steps for providing regular medical treatment to HIV+ infected patients no doubt has improved but the affected patients do apprehend a laxity and thus pray for a direction to be given to the concerned authority including the Department of Health as well as Bihar State AIDS Control Society to maintain the same standard of medical facility all through the year as well as to maintain regular supply of medicines to such patients in the other centers running across the State as well.

We are in absolute agreement with the concern shown by the petitioner in the maintenance of facility/ medicines on regular basis to the patients, all through the year and there cannot be any contest to what the petitioner raises nor this litigation can be called adversarial.

Having observed as such, that the cause raised by the petitioner has been addressed to and medical facility having improved at the Anti Retroviral Therapy (ART) Center at Saran at Chapra, we would expect the concerned authorities i.e. National AIDS Control Organization, New Delhi, the Bihar State AIDS Control Society, Patna as well as the Ministry of Health,

Govt. of India, New Delhi to ensure that the medical facilities to HIV+ patients across the State, at all the ART centres are maintained and the centers are functional with CD4 machine as well as medical facilities as required to cater to such patients, are available all through the year

With the advice above, we dispose of the writ petition.

(Jyoti Saran, J)

(Anjani Kumar Sharan, J)

**Shebani Rose Verma Vs. Ministry of Health and Family welfare W.P. (C)
8475/2018**

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*IN THE HIGH COURT OF DELHI AT NEW DELHI

+W.P.(C) 8475/2018

SHEBANI ROSE VERMA

..... Petitioner

Through: Ms. Sija Nair Pal, Advocate

versus

MINISTRY OF HEALTH & FAMILY WELFARE & ANR.

..... Respondents

Through: Ms. Shiva Lakshmi, CGSC for UOI.

CORAM:

HON'BLE THE CHIEF JUSTICE

HON'BLE MR. JUSTICE C.HARI SHANKAR

O R D E R

% 13.08.2018

Notice.

Ms. Shiva Lakshmi, CGSC accepts notice on behalf of the respondents.

Counter affidavits be filed within four weeks. Rejoinder thereto, if any, within two weeks thereafter.

List on 26.11.2018.

CHIEF JUSTICE
C.HARI SHANKAR, J

AUGUST 13, 2018

Ms XXX versus The State of Nagaland & 5 Ors W.P (C) 6 (K) of 2018

Date of application for the copy. GAJICN/000155/2018	Date fixed for notifying Member for stamps and folios.	Date of delivery of requisite stamps and folios.	Date on which the copy was ready for delivery.	Date of handing over to the applicant.
07-06-19	04-06-19	07-06-19	08-06-19	06-06-19



THE GAUHATI HIGH COURT
(HIGH COURT OF ASSAM, NAGALAND, MIZORAM AND ARUNACHAL PRADESH)
KOHIMA BENCH

Case No. : (A.(Civil) 150/2018



1:XXX
DIMAPUR

VERSUS

1:THE STATE OF NAGALAND AND 5 ORS
THROUGH ITS CHIEF SECRETARY, N.L CIVIL SECRETARIAL GOVT. OF
N/L

2:THE COMMISSIONER AND SECRETARY
DEPT. OF HEALTH AND FAMILY WELFARE
N/L
DEPT. OF HEALTH AND FAMILY WELFARE
N/L
KOHIMA

3:THE PRINCIPAL DIRECTOR
DIRECTORATE OF HEALTH AND FAMILY WELFARE
N/L
DIRECTORATE OF HEALTH AND FAMILY WELFARE
N/L
KOHIMA

4:THE PROJECT DIRECTOR
NAGALAND STATE AIDS CONTROL SOCIETY
N/L
NAGALAND STATE AIDS CONTROL SOCIETY
SECRETARIAT ROAD
KOHIMA
N/L

5:THE ADDITIONAL SECRETARY AND DG



Page No. 24

NATIONAL AIDS CONTROL ORGANISATION (NACO)
 NATIONAL AIDS CONTROL ORGANISATION (NACO)
 DEPT. OF HEALTH AND FAMILY WELFARE
 6TH AND 5TH FLOOR
 CHANDERLOK BUILDING
 36 JANPATH
 NEW DELHI

6 THE UNION OF INDIA
 THROUGH ITS SECRETARY
 THE MINISTRY OF HEALTH AND FAMILY WELFARE
 ROOM NO. 348 'A' WING
 NIRMAL BHAVAN
 NEW DELHI

Advocate for the Petitioner - [KEZHUASENO KIKHI]

Advocate for the Respondent - GOVT ADV NL

Linked Case: PH 6/2018

1-XXX
 DIMAPUR

VERSUS

1 THE STATE OF NAGALAND AND 5 ORS.
 THROUGH ITS CHIEF SECRETARY TO THE GOVT. OF N.I
 NAGALAND CIVIL SECRETARIAT
 KOHIMA
 N.I.

2 THE COMMISSIONER AND SECRETARY
 DEPT. OF HEALTH AND FAMILY WELFARE
 N.I.
 DEPT. OF HEALTH AND FAMILY WELFARE
 N.I.
 KOHIMA

3 THE PRINCIPAL DIRECTOR
 DIRECTORATE OF HEALTH AND FAMILY WELFARE
 N.I.
 DIRECTORATE OF HEALTH AND FAMILY WELFARE
 N.I.



KOPIES

TO THE PROXY-COUNSELLOR
 NATIONAL AIDS CONTROL SOCIETY
 NATIONAL AIDS CONTROL SOCIETY
 SECRETARIAT BUILDING
 KOLKATA
 S.I.

TO THE ADDITIONAL SECRETARY AND I/O
 NATIONAL AIDS CONTROL ORGANIZATION/ACOD
 DEPT. OF HEALTH AND FAMILY WELFARE
 9TH FLOOR
 CHANDRASEKAR BUILDING
 36 JALPAIGI
 NEW DELHI

TO THE UNION OF INDIA
 THROUGH ITS SECRETARY
 THE MINISTRY OF HEALTH AND FAMILY WELFARE
 ROOM NO. 548 'A' WING
 NISMAN BHAVAN
 NEW DELHI

Advocate to the Petitioner - KE/HA/NO/KIK/H
 Advocate for the Respondent - GOVT/ADV/NI

**BEFORE
 HON'BLE MR. JUSTICE KALYAN RAJ SURANA**

ORDER

Date : 04-06-2019

Both sides are duly represented by the learned counsel.

The learned counsel for the petitioner prays for time to file affidavit-in-reply in connection with PIL No.6 (K) of 2018.

Mr. N. Modhul, learned Standing counsel for the respondent Nos. 4 & 5 submits that he would be filing Vakalatnama in respect of respondent Nos. 4 & 5 in the course of the day.

Page No. 44

In view of the nature of grievance raised in the present case, this PIL is admitted for final hearing by issuing Rule returnable within 4 (four) weeks without requiring the petitioner to take fresh steps.

List it for final hearing after **4 (four) weeks**.



Sd/-
JUDGE

Comparing Assistant

Certified to be true Copy

7/2
06/06/2019
Deputy Registrar (Judl.)
Gauhati High Court
Kohima Bench

Authorised U.S. 76 ACT 1 of 1972

• **Maternal Health Care of Refugee Women in India**

Jafar Ullah & Anr. Vs. Union of India and Anr. (Writ Petition (C) No. 859 of 2013

ITEM NO.2+12

COURT NO.1

SECTION PIL-W

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS

Writ Petition (Civil) No.859/2013

JAFFAR ULLAH & ANR.

Petitioner(s)

VERSUS

U.O.I & ORS.

Respondent(s)

(With appln.(s) for exemption from filing O.T. and permission to file Annexures)

WITH W.P.(C) No.793/2017 (X)

(With appln.(s) for intervention, intervention/impleadment, permission to appear and argue in person, permission to file additional documents, impleading party and clarification/direction) W.P.(C) No.870/2017 (PIL-W)

W.P.(C) No.886/2017 (PIL-W)

W.P.(C) No.919/2017 (PIL-W)

(With appln.(s) for appropriate orders/directions) W.P.(C) No.916/2017 (PIL-W)

W.P.(C) No.924/2017 (PIL-W)

(With appln.(s) for intervention/impleadment) W.P.(C) No.955/2017 (PIL-W)

(With appln.(s) for clarification/direction) Diary No(s).32692/2017 (PIL-W) W.P.(C) No.1111/2017 (PIL-W)

(With appln.(s) for permission to appear and argue in person and permission to file appln.(s) for direction)

W.P.(C) No.262/2018

(With appln.(s) for exemption from filing O.T., c/delay in refiling and grant of interim relief)

Date : 09-04-2018 These matters were called on for hearing today.

CORAM :

Signature Not Verified

Digitally signed by CHETAN KUMAR Date: 2018.04.11

15:47:24 IST

Reason:

HON'BLE THE CHIEF JUSTICE

HON'BLE MR. JUSTICE A.M. KHANWILKAR HON'BLE

DR. JUSTICE D.Y. CHANDRACHUD

For Petitioner(s)

Mr. Fazal Abdali, Adv.

Mr. Deepak Kumar Singh, Adv.

Ms. Jyoti Mendiratta, AOR

Continued...

ITEM NOS.33+13

COURT NO.1

SECTION PIL-W

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS

Writ Petition (Civil) No. 859/2013

JAFFAR ULLAH & ANR.

Petitioners

VERSUS

UNION OF INDIA & ORS.

Respondents WITH

W.P.(C) No. 793/2017 (X)

(and IA No.87282/2017-INTERVENTION APPLICATION NAME OF MR. TUSHAR MEHTA, ADVOCATE MAY BE SHOWN IN THE LIST and IA No.88305/2017-INTERVENTION/IMPLEADMENT and IA No.89024/2017- INTERVENTION/IMPLEADMENT and IA No.89100/2017- INTERVENTION/IMPLEADMENT and IA No.90627/2017-INTERVENTION APPLICATION and IA No.93032/2017-INTERVENTION/IMPLEADMENT and IA No.93270/2017-INTERVENTION/IMPLEADMENT and IA No.94489/2017- INTERVENTION/IMPLEADMENT and IA No.97090/2017-INTERVENTION APPLICATION and IA No.97091/2017-PERMISSION TO APPEAR AND ARGUE IN PERSON and IA No.100563/2017-PERMISSION TO FILE ADDITIONAL

DOCUMENTS and IA No.107396/2017-impleading party and IA No.107402/2017-INTERVENTION APPLICATION and IA No.130783/2017-INTERVENTION APPLICATION [D.NO.32692/2017 TO BE TAKEN UP WITH THIS MATTER] and IA No.132156/2017-INTERVENTION APPLICATION and IA No.14970/2018-CLARIFICATION/DIRECTION)

W.P.(C) No. 870/2017 (PIL-W) (FOR ADMISSION) W.P.(C) No. 886/2017 (PIL-W)

W.P.(C) No. 919/2017 (PIL-W)

(FOR ADMISSION and IA No.97138/2017-APPROPRIATE ORDERS/DIRECTIONS)

W.P.(C) No. 916/2017 (PIL-W)

W.P.(C) No. 924/2017 (PIL-W)

(FOR ADMISSION and IA No.104649/2017-INTERVENTION/IMPLEADMENT and IA No.104654/2017-INTERVENTION/IMPLEADMENT) W.P.(C) No. 955/2017 (PIL-W)

(FOR ADMISSION and IA No.101081/2017-CLARIFICATION/DIRECTION) Diary No(s). 32692/2017 (PIL-W)

W.P.(C) No. 1111/2017 (PIL-W)

(FOR ADMISSION and IA No.119942/2017-PERMISSION TO APPEAR AND ARGUE IN PERSON and IA No.119939/2017-PERMISSION TO FILE APPLICATION FOR

SignaDtireINoRt VeErifiCed TION)

Digitawilly s.ignPed b.y (C) No. 262/2018 (PIL-W)

14:24:(53 FISTOR ADMISSION and IA No.33189/2018-GRANT OF INTERIM RELIEF and IA No.33187/2018-EXEMPTION FROM FILING O.T. and IA No.33186/2018-CONDONATION OF DELAY IN REFILEING)

W.P.(C) No. 442/2018 (PIL-W)

(FOR ADMISSION and I.A. No. 66802/2018-CLARIFICATION/DIRECTION)

Date : 11-05-2018 This matter was called on for hearing today.

CORAM :

HON'BLE THE CHIEF JUSTICE

HON'BLE MR. JUSTICE A.M. KHANWILKAR

HON'BLE DR. JUSTICE D.Y. CHANDRACHUD

For Petitioners

Mr. Colin Gonsalves, Sr. Adv.

Ms. Sneha Mukherjee, Adv.

Mr. Fazal Abdali, Adv.

Mr. Deepak Singh, Adv.

Ms. Jyoti Mendiratta, AOR

Mr. Prashant Bhushan, AOR

Ms. Cheryl D'Souza, Adv.

Mr. P.V. Surendra Nath, Sr. Adv.

Mr. Subhash Chandran K.R., Adv.
Ms. Resmitha R. Chandran, AOR
Ms. Yogamaya M.G., Adv.
Ms. Lekha, Adv.
Mr. P.V. Dinesh, AOR
Mr. Sindhu T.P., Adv.
Mr. Bijan Ghosh, Adv.
Mr. Purushottam Sharma Tripathi, AOR
Ms. Sangeeta Madan, Adv.
Mr. Mukesh Kumar Singh, Adv.
Mr. Ravi Chandra Prakash, Adv.
Ms. Vani Vyas, Adv.
Mr. L. Nidhiram Sharma, Adv.
Mr. Shantanu Jugtawat, Adv.
Dr. Ashwani Kumar, Sr. Adv.
Ms. Sujeeta Srivastava, AOR
Ms. Raushan Tara Jaswal, Adv.
Mr. R.G. Gopalakrishnan, Adv.
Mr. Colin Gonsalves, Sr. Adv.
Mr. Fazal Abdali, Adv.
Mr. Satya Mitra, AOR
Mr. Sajan Poovayya, Sr. Adv. Mr..
Mr. R.H.A. Sikander, Adv.
Mr. Prateek Gupta, Adv.
Mr. Mohd. Danish, Adv.
Mr. Mohd. Shakim, Adv.
Mrs. Sudha Gupta, AOR
Mr. A. Chariha, Adv.
Mr. Kunal Chatterji, AOR
Ms. Maitrayee Banerjee, Adv. Petitioner-in-person

For Respondents/
Applicants

Mr. Tushar Mehta, ASG
Mrs. Madhavi Divan, Adv.
Mr. Rajat Nair, Adv.
Mr. Kanu Agrawal, Adv.
Mr. Arijit Prasad, Adv.
Mr. S.S. Shamsbery, Adv.
Mr. B.V. Balaram Das, AOR
Mr. Gurmeet Singh Makker, AOR
Ms. Niranjana Singh, Adv.
Mr. S. Wasim Quadri, Adv.
Mr. Suhaan Mukerji, Adv.
Ms. Astha Sharma, Adv.
Mr. Vishal Prasad, Adv.
Mr. Amjid Maqbool, Adv.
Mr. Amit Verma, Adv.
M/s. PLR Chambers & Co., AOR
Mrs. G. Indira, Adv.
Ms. Anitha Shenoy, Adv.
Ms. Srishti Agnihotri, Adv.
Ms. Remya Raj, Adv.
Mrs. K. Enatoli Sema, Adv.
Mr. Edward Belho, Adv.
Mr. Amit Kumar Singh, Adv.
Mr. K. Luikang Michael, Adv.
Mr. Debasis Misra, AOR
Mr. Manohar Singh Bakshi, Adv.
Mr. Binay Kumar Jha, Adv.
Mr. Parvez Bashista, Adv.
Ms. Alpana Sharma, Adv.

Mr. B.K. Satija, AAG, Haryana
Mr. Sanjay Kumar Visen, AOR
Ms. Sushma Suri, AOR
Ms. Archana Pathak Dave, AOR
Mr. Suvidutt M.S., AOR
Mr. Pranav Sachdeva, AOR
Mr. Lakshmi Raman Singh, AOR
Dr. Rajeev Dhawan, Sr. Adv.
Mr. Subhasish Bhowmick, Adv.
Mrs. Honey Verma, Adv.
Mr. Goldy Goyal, Adv.
Mr. Yatish Mohan, Adv.
Ms. Vinita Y. Mohan, Adv.
Mr. Sumant Jha, Adv.
Dr. K.N. Tripathy, Adv.
Mr. Somiran Sharma, AOR
Mr. Amit Kumar, Adv.

UPON hearing the counsel the Court made the following

O R D E R

In pursuance of our earlier order, the compliance Report of the Committee on the present status of health facilities for the Rohingyas staying at Nuh Block, District Mewat, Haryana and Kanchankunj, Kalindikunj, Delhi has been filed. With regard to the habitation, health service delivery, water, sanitation, hygiene, electricity and education in respect of Nuh Block, District Mewat, Haryana, the Report states thus:-

“1. Habitation:

The members visited 2 (two) settlements of Rohingyas within Nuh Block of Mewat District i.e.

Ferozpur Namak and Shahpur Nangli.

The members of the Rohingya community are residing in Camps made of neat rows of huts with electricity connection and water provision. The hutments are made up of bamboo, plastic sheets (Tirpal) etc. There are open spaces all around and the camps are well spread out.

2. Health service delivery:

The settlements visited have following health facilities in and around the Nuh Block:

- Sub Centre (SC) Ferozpur Namak, which has recently been made functional as a Health & Wellness Center to provide comprehensive primary health care services (distance from Ferozpur Namak -500 meters)
- Community Health Centre (CHC), Nuh (distance from Ferozpur Namak - 4 Kms distance)
- Primary Health Centre (PHC), Nuh (distance from Ferozpur Namak - 4 kms)
- Saheed Hasan Khan Mewati Medical College – 8 kms away from Ferozpur Namak.

The above health centres are providing all primary, secondary and tertiary health care services as per standard National/State guidelines. The Rohingyas have equal access to these health services as any other citizen in the district.

The ANM visits the camps once a week and provides basic primary health care like screening for communicable diseases, ante natal check-up, immunization etc. The ladies of the Rohingyas have home deliveries. On being enquired about its reason, it was stated that they prefer home

deliveries rather than going to the hospitals. Only in case of any complication, the pregnant women are taken to the hospitals.

The Health services are being provided by trained and competent health care providers. It was observed that the ANM providing outreach services at the visited sites had an experience of over 6 years and had adequate knowledge and skills to meet the health needs of the population. The Primary Health Centre Medical Officer and the Sub Centre ANM also had enough supplies of drugs required for providing outreach health camps.

The ANM had detailed knowledge and data of the population required for providing maternal, child health, family planning services. Eligible Couple list and 0-2 year age group children list were maintained by ANM. No Maternal Death or child death was reported.

Pregnant women, lactating mothers and children (6 months – 6 years) of the Rohingya community are registered with the Anganwadi worker and have availed benefits under the Supplementary Nutrition Programme (SNP), medicines like Albendazole, iron folic acid, etc. are being distributed by ANMs and Anganwadis.

Ferozpur Namak camp has a total population of 301, of which 43 children are in the age group of 0-2 years. Shahpur Nangli camp has a population of 507 of which 85 are in the age group of 0-2

years. So, the birth rate is quite high in the population. Even though family planning services are being provided to the eligible couples by the ANM, the usage of family planning methods is low by the inhabitants.

Regular screening for communicable diseases are undertaken and no case of TB, Malaria or Dengue was reported from the sites visited. No disease outbreak was reported.

Health Camps, Routine immunization programme and intensified pulse polio programme were conducted for these population at monthly intervals and all records were maintained at the Sub Centre.

For example:

(a) Ferozepur Namak:

- i. On 24.3.2018 Five Pregnant women and Eleven children were immunized.
- ii. On 21.4.2018 One Pregnant woman and four children were immunized.
- iii. Anganwadi: 25 got SNP, 35 immunizations, 13 pregnant women and 15 lactating mothers availed of other benefits.

(b) Shahpur Nangli:

- i. On 21.4.2018 in the health camp, there was an OPD of 81 patients of which 21 females and 19 male patients were provided treatment.
- ii. Anganwadi: 30 got SNP, 8 immunization, 6 pregnant women and 4 lactating mothers availed of other benefits.

The Rohingyas has access to the free ambulance services for health emergencies provided by the State Government.

3. Water, Sanitation and Hygiene:

The camp at village Ferozpur Namak has one piped water supply provided through the panchayat. The water was found to be potable and the site for water delivery was hygienic and well maintained. The waste water gets drained to a common drain (nullah) behind the camp. In village Shahpur Nangli camp, water supply is provided by tankers through the Panchayat and one water tank with 14000 liters capacity was found in the camp. The tanks were found to be clean and well maintained and no water seepage or water collection around the tank was observed. However, the community requested for one more water tank for summer season for the inhabitants of the Shahpur Rohingyas.

Each and every hut in the site visited had its own toilet and open defecation was not a practice. The overall hygiene of the visited camps was found to be good and there was no collection of garbage/solid waste in open/visible areas.

4. Electricity:

The camp at village Ferozpur Namak, and Shahpur Nangli both had electricity supply. The electricity was available for around 12 hours a day on an average. This was the pattern in the entire district based on the availability of power supply received by the district. Some of the huts had refrigerator, air cooler etc. One of the huts was also converted to a local shop for selling daily utilities which even had a computer installed.

5. Education:

The Committee visited Govt. Secondary School, Ferozpur Namak, where the children of the Rohingyas are studying. There are around 500 children and 19 teachers. In this primary school there are 41 Rohingya children who are studying and all the facilities are being provided to these children similar to Indian citizens without any discrimination. The Rohingya children are given the mid-day meals at-par with the local children. The school administration also provides them all facilities including free books, bags, etc.

In the Government Secondary School visited at Ferozpur Namak, 39 children in Class II, 6 children in Class III and one child in Class IV are pursuing their education. The Committee interacted with the class II girl children, who are regularly going to the school.

Shahpur Nangli Rohingya settlement had a Madrasa and many prefer to send their children to Madarsa.

Copy of attendance register and relevant photographs are enclosed in Annexures.

The Committee also visited another slum in the vicinity, namely Madina Basti inhabited by local Indian citizens. In comparison to the Rohingyas, the overall hygiene and sanitation was not found to be satisfactory. There was no electricity connection. Water supply was scarce even though the inhabitants were living in the area for over 15 years. Outreach services for immunization and ante natal care are being provided to the residents. Three children, present during that time of visit, were found to be home delivered. The inhabitants had valid Aadhaar card and Election ID card.

Concluding Remark:

The Committee had an overall observation that the Rohingyas are not being discriminated against despite being illegal migrants. They are being provided with basic facilities for health care, water, sanitation and education. The quality and comprehensiveness of the services provided are not less than those provided to the Indian citizens and are within the available infrastructure and resources of the District.”

In respect of Kanchankunj, Kalindikunj, Delhi, the Committee has with regard to access to health care system, recorded its findings as under:-

“Access to health care system:-

- A. List of Health facilities in the nearby locality is as under:-
- a) MCW Center Madanpur Khaddar (MCD)
 - b) Polyclinic Madanpur Khaddar (Delhi Govt.)
 - c) SPUHC.Abul Fazal (NRHM) 4 km (Delhi Govt.)
 - d) AAMC Abul Fazal Part-2 (3 km) (Delhi Govt.)
 - e) AAMC Shaheen Bagh 4 km (Delhi Govt.)
 - f) DGD Batla House 7 km (Delhi Govt.)
 - g) Rural Health Center of HAH Centenary Hospital (Majeedia) (Pvt.) (2-3 km)
 - h) Safdarjung Hospital (10 km) (Central Govt.)
 - i) Al Sifa Hospital (6 km) Abul Fazal
 - j) Majeedia Hospital (10 km)
 - k) Mobile van from Jamia Hamdard (Pvt.) visits the area once a week.
- B. Immunization:- Every month Delhi Government Dispensary (DGD) Srinivaspuri conducts 10-12 sessions of immunization at 10 different sites covering all blocks of JJ Colony and Kanchankunj. Most of the children were found to have received age appropriate immunization. Cards of some children were also verified. ANMs visit the camp for vaccinations during pulse polio campaign. Routine Immunization services are mainly provided by the MCW Center Madanpur Khaddar, nearby health center.
- C. Maternal Health:- ANC care and investigations are being provided at nearby health facilities/ Centers. Mother and child protection (MCP) Cards were examined and found to bear MCTS/ RCH number (Mother and child tracking system). Birth certificates issued by MCD to the children were also examined.
- However, most of the deliveries are taking place at home and only complicated cases go to Safdarjung Hospital, which is about 10 km away. When enquired about the factors for home deliveries, the response received was that they prefer not to go to any health facility for normal delivery.
- D. Family Planning:- In spite of the access and availability of all family planning services being provided by the local health authorities, acceptance of family planning methods was limited.
- E. Outreach services:- ANM for Maternal and Family Planning Community Outreach services has also been made available by the local health authorities. In addition, Mobile Health Van comes once a week from Jamia Hamdard (Pvt.) centre to treat minor illness. For major illness, the inhabitants visit nearby public/trust/private health facilities.

There is no reported incidence of Maternal or Child death in the last 5 years.”

It is submitted by Mr. Colin Gonsalves, learned senior counsel and Mr. Prashant Bhushan and Ms. Sneha Mukherjee, learned counsel appearing for the petitioners that school children are not getting books and other benefits. They have also projected that as far as the health care system is concerned, the facilities are denied to them, because of lack of proper identity.

Dr. Rajeev Dhawan, learned senior counsel would submit that human rights are extremely sacred and the same have to be given full play in the completest sense in respect of a non-citizen also, for Article 21 of the Constitution which embraces human rights and human rights correspondingly responds to the said article, and hence, there cannot be any discord between the two concepts.

Dr. Ashwini Kumar, learned senior counsel appearing for the petitioners in Writ Petition (Civil) No. 886/2017 would submit that India being a civilized and developed democracy has to stand by the fundamental concept and essential conception of human rights. Mr. P.V. Dinesh, learned counsel for the petitioners in Writ Petition (Civil) No. 262/2018 with anguish and concern, submitted his experience in a camp.

We do not intend to enter into all the issues that have been canvassed before us. We may clearly state that the same shall be addressed to at the time of final hearing of the writ petitions and the interlocutory applications.

However, for the present, we issue the following directions:-

- (i) As far as Nuh Block, District Mewat, Haryana is concerned, the Sub-Divisional Magistrate or the equivalent authority of District Mewat, Haryana and in respect of Kanchankunj, Kalindikunj, Delhi, the concerned jurisdictional Revenue Magistrate, Delhi are appointed as the nodal officers. The said position is accepted by Mr. Tushar Mehta, learned ASG.
- (ii) Parents or any relative or a guardian of a child or a patient, can go with a grievance to the Nodal Officer, if any facility, as stated in the Status Report is denied to him/her. The Nodal Officer shall do the needful, as stated in the Status Report.

At this juncture, Mr. Kunal Chatterji, learned counsel for the West Bengal Commission for Protection of Child Rights submitted that there is difficulty in uniting the children of Rohingyas who are separated from their parents. Mr. Tushar Mehta, learned ASG shall obtain instructions in the matter and if there is any problem in this regard, the concerned authority of the Union of India can apprise the Commission so that an appropriate view can be taken.

Let the matter be listed on 23.8.2018.

(Deepak Guglani)

Court Master

(H.S. Parasher)

Assistant Registrar

ACCESS TO ADEQUATE NUTRITION**Smt. Mutum Romanandi Devi Vs. State of Manipur & Ors, WP(C) NO. 28 of 2017**

IN THE HIGH COURT OF MANIPUR AT IMPHAL

Writ Petition (C) No. 28 of 2017

Smt. Mutum Romanandi Devi, aged about 35 years, W/O M. Rajesh Singh, a resident of Hiyangthang Makha Leikai, P.O. & P.S. Wangoi Imphal West District, Manipur. -Petitioner

Versus

1. The State of Manipur through the Principal Secretary (Social Welfare), Government of Manipur, Manipur Secretariat, South Block, P.O. & P.S. Imphal West District, Manipur.
2. The Director, Social Welfare Department, Government of Manipur, P.O. & P.S. Imphal, Imphal West District, Manipur.
3. The Union of India through the Secretary, Ministry of Women and Child Development, Government of India, Shastri Bhawan, Dr. Rajendra Prasad Road New Delhi 110001.

-Respondents

BEFORE

THE HON'BLE MR. JUSTICE N. KOTISWAR SINGH

For the Petitioner : Ms. Ng. Sarah, Advocate

For the Respondents : Ms. Sundari, GA

for Respondents Nos. 1 & 2

Mr. S. Samarjeet, Advocate

for Respondents No. 3

Date of Order : 18-01-2017

O R D E R

Heard Ms. Ng. Sarah, learned counsel for the petitioner as well as Ms. Sundari, learned GA for the respondent Nos. 1&2 and Mr. S. Samarjeet, learned counsel for the respondent No. 3.

When this matter was taken up, Ms. Sarah, learned counsel for the petitioner submits that similar order had been passed by this Court in WP(C) No. 811 of 2016 on 19-10-2016, which reads as follows:

“Heard Mr. M. Rakesh, learned counsel appearing for the petitioners and learned counsel appearing for the State and Mr. S. Suresh, learned counsel appearing for the Union of India.

According to the case of the petitioner the family of the petitioner, a pregnant woman, belong to the category of Priority House Hold as per Ration Card issued by the Consumer Affairs, Food & Public Distribution, Government of Manipur. The ration card is in the name of KonthoujamBimola Devi, mother-in-law of the petitioner. Since the petitioner is carrying pregnancy, expecting delivery by 5-3-2017, used to go to medical centres for regular prenatal check up. During regular check up the Doctor prescribed different kind of medicines and has also advised to have nutritional food. In that situation, an application was submitted to the Director, Department and Social Welfare, Government of Manipur to provide necessary nutritional support and also maternity benefit as provided under Section 4 of the National Food Security Act, 2013. According to the learned counsel no such decision has been taken by the Director, Department of Social Welfare, Government of Manipur, as a result of which the petitioner is being denied with the benefit provided under the said Act.

In view of the above facts and circumstances as stated above, this writ application is disposed of directing the respondent No. 3, the Director, Department of Social welfare, Government of Manipur, to take decision over the representation filed on 24-08-2016, to the effect stated above, within a fortnight from the date of receipt of a copy of this order.

Thus, this application stands disposed of.”

In view of the submission of the learned counsels for both the parties, this Court is of the view that this writ petition can be disposed of in terms of the aforesaid order with similar direction.

Accordingly, the present writ petition is disposed of with the direction to the respondent No. 2, Director, Social Welfare Department, Government of Manipur to take a decision over the representation filed by the petitioner on 9-11-2016 as directed in W.P.(C) No. 811 of 2016 within a fortnight from the date of receipt of a copy of this order.

Sd/-

N. Kotiswar Singh

Judge

Alka Rajputh Vs. State of Assam & 6 Others, WP(C) No. 2504/17

WP(C) 2504/2017 BEFORE HON'BLE MR. JUSTICE PRASANTA KUMAR DEKA Heard Ms. D. Ghosh, the learned counsel for the petitioner and Ms. B. Bora, learned counsel, appearing on behalf of the respondent Nos. 2 and 3. Also heard Ms. A. Das learned counsel for the respondent No. 4 and Ms. A. Das, learned counsel, appearing for the respondent No. 1. This writ petition has been filed by the petitioner with regard to non compliance by respondents of certain benefits due to a lactating mother. A representation dated 4.2.2017 also made to the Director, Directorate of Health Services, Assam and the respondent No. 6. As submitted by the learned counsel appearing for the petitioner, the said representation has not yet been disposed of nor has any action been initiated on the basis of the said representation with respect to the grievance made by the petitioner. Ms. Bora accordingly will enquire with the concerned official and intimate this court about the fate of the representation on the next date so fixed. Let this matter be listed on 11.5.2017.

Continued..

WP(C) 2504/2017 BEFORE HON'BLE MR. JUSTICE A.M. BUJOR BARUA It is submitted by Mr. Y. Doloi, learned Additional Advocate General, Assam that a cheque bearing No.287007 dated 28.02.2017 was handed over to the petitioner and the petitioner had received the amount of ₹1,400/-. Ms. D. Ghosh, learned counsel for the petitioner, on the other hand, submits that she does not have the required information whether the cheque had been received by the petitioner or not. In such view of the matter, list the matter again on 29.05.2017, on which the learned counsel for the petitioner shall inform the Court whether the cheque had been received by the petitioner or not.

Continued..

WP(C) 2504/2017 BEFORE HON'BLE MR. JUSTICE MICHAEL ZOTHANKHUMA Heard Ms. D Ghosh, counsel for the petitioner and Mr. Y Doloi, Additional Advocate General, Assam. The petitioner by way of this writ petition claims payment of Rs.1400/- under the Janani Suraksha Yojana Scheme. The other claim made by the petitioner is with regard to payment of Rs.6000/- under Section 4(b) of the National Food Security Act, 2013. The petitioner also claims payment

of Rs.1000/- for completing her 1st and 3rd ante-natal checkups. The counsel for the petitioner submits that while the petitioner was given Rs.500/- only for her 2nd ante-natal checkup, she has not paid any amount thereafter, as the Asha worker did not take her for 1st and 3rd ante-natal checkups, due to the negligence of the Asha worker. Mr. Y Doloi, Additional Advocate General has submitted a letter dated 20.05.2017 issued by the National Health Mission, office of the District Health Society, Sonitpur which states that the petitioner was given Rs.500/- for her 2nd ante-natal checkup. The petitioner was not paid any other amount for the 1st and 3rd ante-natal checkups as the fund requirement was not made to the NHM by Duhali Tea Garden. The letter dated 20.05.2017 also states that the petitioner was not given Mamata Kit as it was out of stock. Mr. Y Doloi, Additional Advocate General submits that Rs.1400/- as claimed by the petitioner under the Janani Suraksha Scheme has been given to the petitioner. He submits that the respondents would consider giving the Rs.1000/-, which the petitioner was entitled under the 1st and 3rd ante-natal checkups. He also submits that Mamata Kit will be given to the petitioner as and when the stock is available in the Tea Garden Hospital. Mr. Y Doloi, also submits that the petitioner's claim for payment of Rs. 6000/- as per Section 4(b) of the National Food Security Act, 2013 will be considered by the Director of Social Welfare as the petitioner's representation dated 04.02.2017 on that count has not been decided till date. On hearing the counsel for the parties, this Court directs the Director of Health Services to issue to the petitioner Mamata Kit within a period of 1 (one) month from the date of receipt of a copy of this order. The Director, shall consider the petitioner's letter dated 04.02.2017, with regard to payment of Rs. 1000/-, which she would have received under the 1st and 3rd ante-natal checkups and pay the same to the petitioner if she is so entitled to the same. The Director of Health Services shall take a decision on the matter within 1 (one) month from the date of receipt of this order. The Director of Social Welfare Department shall consider the petitioner's representation dated 04.02.2017 with regard to payment of Rs.6000/- under Section 4(b) of the National Food Security Act, 2013 and if found eligible shall make payment of the same within a period of 1 (one) month from the date of receipt of a copy of this order. The writ petition is accordingly disposed of.

**Pranita Kalita Vs. Union of India & 13 Others; WP(C) No. 7910/16; and
Pranita Kalita Vs. Sri SS Meenakshi Sundaram, Director, Directorate of
Social Welfare; Contempt Petition(C) No. 224/2017 Gauhati High Court**

WP(C) 7910/2016 B E F O R E HON'BLE MR. JUSTICE ACHINTYA MALLA BUJOR BARUA Heard Ms. D Ghosh, learned counsel for the petitioner. It is submitted that under Section 4 of the National Food Security Act, 2013, every pregnant woman and lactating mother are entitled to a maternity bene fit of not less than Rs.6000/-. It is stated that under the said arrangement, th e aforesaid amount of Rs.6000/- is given in two installments. The first installm ent is given during pregnancy period and the balance amount is given after 6(six) months of the delivery of the child. It is submitted that even that amount of 6000/- has not been paid to the petitioner by the respondent authorities. Accordingly, the respondent authorities are directed to pay the 1st inst allment amount of Rs.3000, which the petitioner is entitled, within a period of 7(seven) days from the date of receipt of a certified copy of this order. Mr. KK Upadhyaya, learned State counsel shall submit an affidavit statin g, therein, in details, as to what required steps have been taken by the respond ent authorities for implementing the following schemes: 1. Janani Shishu Suraksha Karyakram (JSSK) 2. Mamoni Scheme 3. Mamata Scheme 4. Indira Gandhi Matritva Sahyog Yajna (IGMSY) List the matter after 2(two) weeks.

**Peoples Union for Civil Liberties vs. Union of India, and Others, W.P.
(C) 227/2015**

ITEM NO.303

COURT NO.8

SECTION PIL(W)

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS

Writ Petition(s)(Civil) No(s).277/2015

PEOPLE'S UNION FOR CIVIL LIBERTIES

Petitioner(s)

VERSUS

UNION OF INDIA & OTHERS

Respondent(s) (with office report)

Date : 06/11/2015 This petition was called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE MADAN B. LOKUR

HON'BLE MR. JUSTICE UDAY UMESH LALIT

For Petitioner(s)

Mr. Colin Gonsalves, Sr. Adv.

Mr. Kamlesh Kumar Mishra, Adv.

Mr. Satya Mitra, AOR

For Respondent(s)

Mr. S. Wasim A. Qadri, Adv.

Ms. Purnima Bhat Kak, Adv.

Mrs. Anil Katiyar, AOR

UPON hearing the counsel the Court made the following

O R D E R

Learned counsel for the petitioner says that there is already another petition pending on the same issue, being W.P.(C) No.196 of 2001.

List the matter before the Bench dealing with that matter.

(SANJAY KUMAR-I)

AR-CUM-PS

(JASWINDER KAUR)

COURT MASTER

Continued...**ITEM NO.9****COURT NO.5****SECTION PIL(W)**

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS

Writ Petition(s)(Civil) No(s).277/2015

PEOPLE'S UNION FOR CIVIL LIBERTIES

Petitioner(s)

VERSUS

UNION OF INDIA & OTHERS

Respondent(s)

(WITH APPLN. (S) FOR exemption from filing O.T. and Office Report) Date : 23/03/2017 This petition was called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE MADAN B. LOKUR

HON'BLE MR. JUSTICE DEEPAK GUPTA

For Petitioner(s)

Mr.Colin Gonsalves, Sr. Adv. Olivia

Ms. Bang, Adv.

Mr. Aditya Srivastva, Adv.

Mr. Satya Mitra, AOR

For Respondent(s) UOI

Mr. Ajit Kumar Sinha, Sr. Adv.

Mr.Gaurav Sharma, Adv. Sunita

Mr. Sharma, Adv.

Mr. R.K. Rathore, Adv.
Mr. S.S. Rawat, Adv.
Mr. G.S. Makker, Adv.
Mr. S. Wasim A. Qadri, Adv.
Mr. Raj Bahadur Yadav, Adv.
Mr. A.K. Kaul, Adv. Purnima Bhat Kak, Adv.
Mrs. Anil Katiyar, AOR

For States of

Bihar

Mr. Gopal Singh, AOR
Mr. Manish Kumar, Adv.
Ms. Varsha Poddar, Adv.

Chhattisgarh

Mr. Atul Jha, Adv.
Mr. Sandeep Jha, Adv.

Signature Not Verified

Digitally signed by SANJAY KUMAR Date: 2017.03.23

16:54:26 IST

Mr. Dharmendra Kumar Sinha, AOR

Reason Gujarat

Ms. Hemantika Wahi, AOR Ms. Shodhika Sharma, Adv. Ms. Jesal Wahi, Adv.

Haryana

Mr. Ajay Bansal, AAG
Mr. Gaurav Yadava, Adv.
Mr. Sanjay Kumar Visen, AOR

J&K

Mr. M. Shoeb Alam, Adv.
Ms. Fauzia Shakil, Adv.
Mr. Ujjwal Singh, Adv.
Mr. Mojahid Karim Khan, Adv.

M.P.

Mr. Purushaindra Kaurav, AAG Mr. Arjun Garg, AOR

	Mr. Manish Yadav, Adv.
	Ms. Anuradha Mishra, Adv.
Maharashtra	Mr. Nishant Ramakantrao Katneshwarkar, AOR
	Mr. Arpit Rai, Adv.
	Ms. Deepa Kulkarni, Adv.
Manipur	Mr. Sapam Biswajit Meitei, Adv.
	Mr. Naresh Kumar Gaur, Adv.
	Mr. M.N. Singh, Adv.
	Mr. Ashok Kumar Singh, AOR
Nagaland	Mr. Edward Belho, AAG
	Ms. K. Enatoli Sema, AOR
	Mr. Amit Kumar Singh, Adv.
	Mr. K. Luikang Michael, Adv.
	Ms. Elix Gangmei, Adv.
	Mr. Z.H. Isaac Haiding, Adv.
Rajasthan	Mr. Jayant Bhatt, Adv.
	Ms. Jyoti Sharma, Adv.
	Mr. Vipin Kumar, Adv.
	Mr. Milind Kumar, AOR
Sikkim	Ms. Aruna Mathur, Adv.
	Mr. Avneesh Arputham, Adv.
	Ms. Anuradha Arputham, Adv.
	Mr. Amit Arora, Adv.
	for M/s Arputham Aruna & Co.
Tamil Nadu	Mr. B. Balaji, AOR
Telangana	Mr. S. Udaya Kumar Sagar, AOR
	Mr. Mrityunjai Singh, Adv.
Tripura	Mr. Gopal Singh, AOR
	Mr. Rituraj Biswas, Adv.
	Ms. Varsha Poddar, Adv.

Uttar Pradesh	Mr. Irshad Ahmad, AAG Mr. Vinay Garg, AOR
West Bengal	Mr. Soumitra G. Chaudhuri, Adv. Mr. Parijat Sinha, AOR
A&N Islands	Mr. Bhupesh Narula, Adv. Mr. K.V. Jagdishvaran, Adv. Mrs. G. Indira, AOR
Chandigarh	Mr. Chandra Prakash, AOR
Puducherry	Mr. V.G. Pragasam, Adv. Mr. Prabu Ramasubramanian, Adv. Mr. Apoorva Bhumes, AOR Mr. Chirag M. Shroff, AOR Ms. Sarika Soam, Adv. Mr. Jatinder Kumar Bhatia, AOR Mr. Ajay Kapur, AAG Mr. Anirudh Singh, Adv. Mr. K.N. Madhusoodhanan, Adv. Mr. T. G. Narayanan Nair, AOR

UPON hearing the counsel the Court made the following

O R D E R

Learned counsel for the Union of India says that he will file a detailed affidavit along with the status report within two weeks.

List the matter on 11th April, 2017.

(SANJAY KUMAR-I)

AR-CUM-PS

(SHARDA KAPOOR)

COURT MASTER

Continued...**ITEM NO.18****COURT NO.5****SECTION PIL(W)**

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS

Writ Petition(s)(Civil) No(s).277/2015

PEOPLE'S UNION FOR CIVIL LIBERTIES

Petitioner(s)

VERSUS

UNION OF INDIA & OTHERS

Respondent(s)

(WITH APPLN. (S) FOR exemption from filing O.T. and Office Report) Date : 11/04/2017 This petition was called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE MADAN B. LOKUR HON'BLE MR.
JUSTICE DEEPAK GUPTA

For Petitioner(s)

Mr. Colin Gonsalves, Sr. Adv. Olivia
Ms. Bang, Adv.
Mr. Satya Mitra, AOR

For Respondent(s)

UOI

Mr. A.N.S. Nadkarni, ASG
Mr. Ajit Kumar Sinha, Sr. Adv.
Mr. Gaurav Sharma, Adv.
Ms. Sunita Sharma, Adv.
Mr. R.K. Rathore, Adv.
Mr. S.S. Rawat, Adv.

Mr. G.S. Makker, Adv.
Mr. S. Wasim A. Qadri, Adv.
Mr. Raj Bahadur Yadav, Adv.
Mr. A.K. Kaul, Adv.
Mr. Anshuman Srivastava, Adv.
Mr. S.S. Rebello, Adv.
Mr. Apoorva Bhumes, AOR
Mrs. Anil Katiyar, AOR

For States of

Bihar

Mr. Gopal Singh, AOR
Ms. Varsha Poddar, Adv.

Chhattisgarh

Mr. Atul Jha, Adv.
Mr. Sandeep Jha, Adv.
Mr. Dharmendra Kumar Sinha, AOR

Signature Not Verified

Digitally signed by SANJAY KUMAR Date: 2017.04.12

17:20:32 IST Reason:

Ms. Puja Singh, Adv.
Ms. Mamta Singh, Adv.
Haryana Mr. Ajay Bansal, AAG
Mr. Sanjay Kumar Visen, AOR
Mrs. Veena Bansal, Adv.
Mr. Devendra Singh, Adv.
Mr. Gaurav Yadava, Adv.
J&K Mr. M. Shoeb Alam, Adv.
Ms. Fauzia Shakil, Adv.
Mr. Ujjwal Singh, Adv.
Mr. Mojahid Karim Khan, Adv.
M.P. Mr. Purushaindra Kaurav, AAG
Mr. Arjun Garg, AOR

	Mr. Manish Yadav, Adv.
	Ms. Anuradha Mishra, Adv.
Maharashtra	Mr. Mahaling Pandarge, Adv.
	Mr. Nishant Ramakantrao Katneshwarkar, AOR
Manipur	Mr. Sapam Biswajit Meitei, Adv.
	Mr. Naresh Kumar Gaur, Adv.
	Ms. Linthoingambi Thongam, Adv.
	Mr. Ashok Kumar Singh, AOR
Mizoram	Mr. K.N. Madhusoodhanan, Adv.
	Mr. T. G. Narayanan Nair, AOR
Nagaland	Ms. K. Enatoli Sema, AOR
	Mr. Edward Belho, Adv.
	Mr. Amit Kumar Singh, Adv.
	Mr. K. Luikang Michael, Adv.
	Ms. Elix Gangmei, Adv.
	Mr. Z.H. Isaac Haiding, Adv.
Punjab	Mr. Ajay Bansal, AAG
	Mr. Kuldip Singh, Adv.
	Mrs. Veena Bansal, Adv.
	Mr. Devendra Singh, Adv.
	Mr. Dheeraj Gupta, Adv.
	Mr. Gaurav Yadava, Adv.
Rajasthan	Mr. Ajay Kapur, AAG
	Mr. Anirudh Singh, Adv.
	Mr. Milind Kumar, AOR
	Mr. Avneesh Arputham, Adv.
	Ms. Anuradha Arputham, Adv.
	Mr. Amit Arora, Adv.
	for M/s Arputham Aruna & Co.
Tamil Nadu	Mr. B. Balaji, AOR
	Mr. S. Kumar, Adv.

Telangana	Mr. S. Udaya Kumar Sagar, AOR
Tripura	Mr. Gopal Singh, AOR Mr. Rituraj Biswas, Adv. Ms. Varsha Poddar, Adv.
Uttar Pradesh	Mr. Irshad Ahmad, AAG Mr. Vinay Garg, AOR Mr. Pankaj Singh, Adv.
Uttarakhand	Mr. Jatinder Kumar Bhatia, AOR West Bengal Ms. Nandini Sen, Adv. Mr. Soumitra G. Chaudhuri, Adv. Mr. Chanchal K. Ganguli, Adv.
A&N Islands	Mr. Bhupesh Narula, Adv. Mr. K.V. Jagdishvaran, Adv. Mrs. G. Indira, AOR
Chandigarh	Mr. Chandra Prakash, AOR Mr. Vivek Singh, Adv.
NCT of Delhi	Ms. Charu Walikhanna, Adv. Mr. Chirag M. Shroff, AOR

UPON hearing the counsel the Court made the following

O R D E R

Learned counsel for the petitioner seeks some time to place some additional documents.

Learned Additional Solicitor General says that a Scheme has been prepared for implementing Section 4(b) of the National Food Security Ms. Aruna Mathur, Adv. Act, 2013. He says that the Scheme will be finalized in consultation with various State Governments to ensure full implementation of the Act.

We direct that the needful be done within eight weeks.

List the matter on 11th July, 2017.

(SANJAY KUMAR-I)

AR-CUM-PS

(SHARDA KAPOOR)

COURT MASTER

Continued...**ITEM NO.9****COURT NO.5****SECTION PIL-W**

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS

Writ Petition(s)(Civil) No(s). 277/2015

PEOPLE'S UNION FOR CIVIL LIBERTIES (PUCL)

Petitioner(s)

VERSUS

UNION OF INDIA & ORS.

Respondent(s)

(FOR EXEMPTION FROM FILING O.T.)

Date : 08-08-2017 This petition was called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE MADAN B. LOKUR

HON'BLE MR. JUSTICE DEEPAK GUPTA

For Petitioner(s)

Mr. Colin Gonsalves, Sr. Adv. Olivia

Ms. Bang, Adv.

Mr. Aditya Srivastva, Adv.

Mr. Satya Mitra, AOR

For Respondent(s)

UOI

Mr. A.N.S. Nadkarni, ASG

Mr. Ajit Kumar Sinha, Sr. Adv.

Mr. R.K. Rathore, Adv.

Mr. S.S. Rawat, Adv.

Mr. G.S. Makker, Adv.
 Mr. S. Wasim A. Qadri, Adv.
 Mr. Raj Bahadur Yadav, Adv.
 Mr. A.K. Kaul, Adv.
 Mr. Anshuman Srivastava, Adv.
 Mr. S.S. Rebello, Adv.
 Mr. Apoorva Bhumes, AOR
 Mrs. Anil Katiyar, AOR

For States of

Bihar

Mr. Gopal Singh, AOR
 Mr. Aditya Raina, Adv.

Chhattisgarh

Mr. Atul Jha, Adv.
 Mr. Sandeep Jha, Adv.
 Mr. Dharmendra Kumar Sinha, AOR

Gujarat

Ms. Hemantika Wahi, AOR
 Mr. Ajay Bansal, AAG
 Mr. Gaurav Yadav, Adv.
 Mr. Vijay Pratap Yadav, Adv.
 Mr. Sanjay Kumar Visen, AOR

J&K

Mr. M. Shoeb Alam, Adv.
 Ms. Fauzia Shakil, Adv.
 Mr. Ujjwal Singh, Adv.
 Mr. Mojahid Karim Khan, Adv.

M.P.

Mr. Sunny Choudhary, Adv.
 Mr. Arjun Garg, Adv.

Maharashtra

Mr. Nishant Ramakantrao Katneshwarkar, AOR Manipur
 Mr. Sapam Biswajit Meitei, Adv.
 Mr. Naresh Kumar Gaur, Adv.
 Mr. Ashok Kumar Singh, AOR

Meghalaya

Mr. Ranjan Mukherjee, Adv.

Mizoram	Mr. T. G. Narayanan Nair, AOR
Nagaland	Ms. K. Enatoli Sema, AOR Mr. Edward Belho, Adv. Mr. Amit Kumar Singh, Adv. Mr. K. Luikang Michael, Adv. Ms. Elix Gangmei, Adv. Mr. Z.H. Isaac Haiding, Adv.
Punjab	Ms. Uttara Babbar, Adv. Ms. Akanksha Choudhary, Adv.
Rajasthan	Mr. Ajay Kapur, AAG Mr. Anirudh Singh, Adv. Mr. Milind Kumar, AOR
Sikkim	Ms. Aruna Mathur, Adv. Mr. Avneesh Arputham, Adv. Ms. Anuradha Arputham, Adv. Mr. Amit Arora, Adv. for M/s Arputham Aruna & Co.
Tamil Nadu	Mr. M. Yogesh Kanna, Adv. Ms. Nithya, Adv. Ms. Mahalakshmi, Adv.
Telangana	Mr. S. Udaya Kumar Sagar, AOR
Tripura	Mr. Gopal Singh, AOR Mr. Rituraj Biswas, Adv.
Uttar Pradesh	Mr. Vinay Garg, AOR Uttarakhand Mr. Ashutosh Kumar Sharma, Adv. Mr. Jatinder Kumar Bhatia, AOR
West Bengal	Mr. Soumitra G. Chaudhuri, Adv. Mr. Chanchal K. Ganguli, Adv.
A&N Islands	Mr. K.V. Jagdishvaran, Adv. Mrs. G. Indira, AOR Mr. J. Hillson Angam, Adv.

Chandigarh Mr. Chandra Prakash, AOR
 Mr. Vivek Singh, Adv.

NCT of Delhi Mr. Chirag M. Shroff, AOR Puducherry
 Mr. V.G. Pragasam, Adv.
 Mr. Prabu Ramasubramanian, Adv.

UPON hearing the counsel the Court made the following

O R D E R

Rejoinder affidavit be filed. List the matter after ten weeks.

(MEENAKSHI KOHLI)
COURT MASTER

(SHARDA KAPOOR)
ASSISTANT REGISTRAR

Continued...**ITEM NO.25****COURT NO.2****SECTION PIL-W**

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS

Writ Petition(s)(Civil) No(s). 277/2015

PEOPLES UNION FOR CIVIL LIBERTIES (PUCL)

Petitioner(s)

VERSUS

UNION OF INDIA & ORS.

Respondent(s)

(WITH APPLN.(S) FOR EXEMPTION FROM FILING O.T.)

Date : 31-10-2018 This petition was called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE MADAN B. LOKUR

HON'BLE MR. JUSTICE S. ABDUL NAZEER

HON'BLE MR. JUSTICE DEEPAK GUPTA

For Petitioner(s)

Mr. Colin Gonsalves, Sr. Adv. Olivia

Ms. Bang, Adv.

Mr. Aditya Srivastva, Adv.

Mr. Satya Mitra, AOR

For UOI Respondent(s)

Mr. Ajit Kumar Sinha, Sr. Adv.

Mr. Arijit Prasad, Adv.

Ms. Suhasini Sen, Adv.
Mr. Ritesh Kumar, Adv.
Mr. G.S. Makker, Adv.
Mr. S. Wasim A. Qadri, Adv.
Mr. Raj Bahadur Yadav, Adv.
Mrs. Anil Katiyar, AOR

For States of

Bihar

Ms. Abha R. Sharma, Adv.
Mr. D.S. Parmar, Adv.
Ms. Sujeta Srivastava, Adv.
Mr. Ankit Mishra, Adv.
Mr. Mahendra Singh, Adv.

Chhattisgarh

Mr. Atul Jha, Adv.
Mr. Sandeep Jha, Adv.

Signature Not Verified

Digitally signed by SANJAY KUMAR Date: 2018.11.01 Reason:

Mr. Dharmendra Kumar Sinha, AOR

Goa

Mr. Anshuman Srivastava, Adv.
Mr. S.S. Rebello, Adv.
Mr. Apoorva Bhumes, Adv.

Gujarat

Ms. Hemantika Wahi, AOR
Ms. Puja Singh, Adv.
Ms. Mamta Singh, Adv.
Ms. Pallavi Baghel, Adv.

Haryana

Mr. Ajay Bansal, AAG
Mr. Sanjay Kumar Visen, AOR
Mr. Gaurav Yadava, Adv.
Ms. Veena Bansal, Adv.

H.P.

Mr. Vikas Mahajan, AAG
Mr. Vinod Sharma, Adv.

J&K	Mr. M. Shoeb Alam, Adv. Mr. Ujjwal Singh, Adv. Mr. Mojahid Karim Khan, Adv.
Jharkhand	Mr. Gopal Prasad, Adv. Mr. S.K. Singh, Adv.
Karnataka	Mr. V.N. Raghupathy, Adv. Mr. Parikshit P. Angadi, Adv. Md. Apzal Ansari, Adv. Mr. Lagnesh Mishra, Adv.
Kerala	Mr. G. Prakash, Adv. Mr. Jishnu M.L., Adv. Ms. Priyanka Prakash, Adv. Ms. Beena Prakash, Adv.
M.P.	Ms. Prachi Mishra, Adv. Mr. Arjun Garg, AOR Mr. Devansh Shrivastava, Adv.
Maharashtra	Ms. Deepa M. Kulkarni, Adv. Mr. Nishant Ramakantrao Katneshwarkar, AOR
Manipur	Mr. Leishangthem Roshmani Kh., Adv. Ms. Maibam Babina, Adv. Ms. Anupama Ngangom, Adv.
Meghalaya	Mr. Ranjan Mukherjee, Adv. Mr. K.V. Kharlyngdoh, Adv. Mr. Daniel Stone Lyngdoh, Adv. Ms. Rachana Srivasatava, Adv. Ms. Monika, Adv.
Mizoram	Mr. K.N. Madhusoodhanan, Adv. Mr. T. G. Narayanan Nair, AOR
Nagaland	Ms. K. Enatoli Sema, AOR Mr. Amit Kumar Singh, Adv.

Punjab	Ms. Uttara Babbar, Adv. Ms. Bhavana Duhoon, Adv. Ms. Deboshree Mukherjee, Adv.
Rajasthan	Mr. Milind Kumar, AOR
Sikkim	Ms. Aruna Mathur, Adv. Mr. Avneesh Arputham, Adv. Ms. Anuradha Arputham, Adv. for M/s Arputham Aruna & Co.
Tamil Nadu	Mr. M. Yogesh Kanna, Adv. Mr. Raja Rajeshwaran, Sr. Adv.
Telangana	Mr. S. Udaya Kumar Sagar, AOR
Tripura	Mr. Shuvodeep Roy, AOR Mr. Rituraj Biswas, Adv.
Uttar Pradesh	Mr. Rajesh K. Singh, Adv. Mr. Susheel Kumar Tomar, Adv. Mr. Ankur Prakash, Adv.
Uttarakhand	Mr. Jatinder Kumar Bhatia, AOR Mr. Ashutosh Kumar Sharma, Adv.
West Bengal	Mr. Suhaan Mukerji, Adv. Ms. Astha Sharma, Adv. Ms. Kajal Dalal, Adv. Ms. Dimple Nagpal, Adv. Mr. Amit Verma, Adv.
A&N Islands	Mr. Mrinal K. Mandal, Adv. Mr. K.V. Jagdishvaran, Adv. Mrs. G. Indira, AOR
Chandigarh	Mr. Chandra Prakash, AOR Mr. Vivek Singh, Adv. Mr. Mohit Darad, Adv.
Puducherry	Mr. V.G. Pragasam, Adv.

NCT of Delhi

Mr. S. Prabu Ramasubramanian, Adv.
Mr. S. Manuraj, Adv.
Mr. Chirag M. Shroff, AOR
Ms. Sanjana Nangia, Adv.
Ms. Joyshree Barman, Adv.
Ms. Monisha Suri, Adv.

UPON hearing the counsel the Court made the following

O R D E R

List the matter in the month of January, 2019.

(SANJAY KUMAR-I)
AR-CUM-PS

(KAILASH CHANDER)
ASSISTANT REGISTRAR

Chhattisgarh Sarv Mazdoor Kalyan Samiti vs State of Chhattisgarh and Ors WP PIL No 63 of 2018

NAFR

HIGH COURT OF CHHATTISGARH, BILASPUR

WPPIL No. 63 of 2018

Chhattisgarh Sarv Mazdoor Kalyan Samiti Through Its Convener, Ashok Singroul S/o Jivan Ram Singroul, Aged About 32 Years, R/o Village Prankhaira, Police Station - Kunda, District Kabirdham Chhattisgarh., District : Kawardha (Kabirdham), Chhattisgarh ---- Petitioner

Versus

1. State Of Chhattisgarh Through Secretary, Department Of Food And Public Distribution, Mantralaya, Naya Raipur, District Raipur Chhattisgarh., District : Raipur, Chhattisgarh
2. Collector, Kabirdham, District Kabirdham Chhattisgarh, District : Kawardha (Kabirdham), Chhattisgarh
3. Sub Divisional Officer (Revenue) Block Pandariya District Kabirdham Chhattisgarh., District : Kawardha (Kabirdham), Chhattisgarh
4. Food Inspector, Block Pandariya, District Kabirdham Chhattisgarh., District : Kawardha (Kabirdham), Chhattisgarh

For Petitioner Ms. Rajni Soren, Advocate

Shri Y.S.Thakur, Addl. Advocate General

Hon'ble Shri Ajay Kumar Tripathi, Chief Justice

Hon'ble Shri Manindra Mohan Shrivastava, Judge

Order On Board

20/07/2018

Per Ajay Kumar Tripathi, Chief Justice

Heard.

This writ application is disposed off with a direction to the Collector – Kabirdham to take cognizance of the grievance raised in the letter dated 24/10/2017 addressed to him which is Annexure P/4 and pass appropriate direction preferably within a period of eight weeks from the date of production of the copy of this order.

Sd/-

(Ajay Kumar Tripathi)

CHIEF JUSTICE

Sd/-

(Manindra Mohan Shrivastava)

JUDGE

Sauradeep Dey vs State of Assam and Ors WP PIL No 7 of 2015

GAHC010023642018



THE GAUHATI HIGH COURT
(HIGH COURT OF ASSAM, NAGALAND, MIZORAM AND
ARUNACHAL PRADESH) Case No. : PIL 7/2018

1:SAURADEEP DEY

HOUSE NO. 4-C, AASTHA ENCLAVE, OPP. G.L. PUBLICATIONS, G.S. ROAD, ULUBARI,
GUWAHATI, ASSAM, PIN-781007.

VERSUS

- 1: THE UNION OF INDIA REPRESENTED BY THE SECRETARY, MINISTRY OF WOMEN AND CHILD DEVELOPMENT, GOVERNMENT OF INDIA, SHASTRI BHAWAN, NEW DELHI.
- 2: THE STATE OF ASSAM REPRESENTED BY COMMISSIONER AND SECRETARY TO THE GOVERNMENT OF ASSAM DEPTT. OF SOCIAL WELFARE ASSAM SECRETARIAT DISPUR GUWAHATI-781006.
- 3: THE COMMISSIONER AND SECRETARY THE DEPARTMENT OF HEALTH AND FAMILY WELFARE GOVERNMENT OF ASSAM ASSAM SECRETARIAT DISPUR ASSAM PIN-781006

Advocate for the Petitioner: MS. D GHOSH

Advocate for the Respondent : ASSTT.S.G.I.

BEFORE
HONOURABLE THE CHIEF JUSTICE
HONOURABLE MR. JUSTICE ARUP KUMAR GOSWAMI

ORDER

Date : 11-04-2019

(A.S. Bopanna, CJ)

Heard Ms. D. Ghosh, learned counsel for the petitioner. Also heard Mr. T.C. Chutia, learned Additional Senior Government Advocate, Assam, appearing for the respondent No.2 and Ms. A. Das, learned counsel, appearing for the respondent No.3.

Though the learned Additional Senior Government Advocate would submit that the provision of the Act is being implemented, the same is disputed by the learned counsel for the petitioner. In that regard though requisite details are not available, the learned counsel for the petitioner refers to the report at Annexure-2 to the writ petition, wherein a study was stated to have been conducted in respect of different Anganwadi Centres named therein. Through the said report, the lacuna in implementation of the provisions of the Act is referred.

In that view, the learned Additional Senior Government Advocate to take note of the report and secure instructions with regard to the Anganwadi Centres, at least as an instance by taking note of one or two Anganwadi Centres, to indicate the factual position and if in fact the implementation of the Act has been done, the details relating to such Anganwadi Centres be furnished to this Court.

To enable the same, list after 6(six) weeks.

Sd/-
JUDGE

Sd/-
CHIEF JUSTICE

Comparing Assistant

IMPLEMENTATION OF ICDS SCHEME AND ESTABLISHMENT OF ANGANWADI CENTRES

Guddu vs. NCT of Delhi & Others, W.P. (C) 10446/2015

\$-14 to 20, 29 and 30

*IN THE HIGH COURT OF DELHI AT NEW DELHI

+W.P.(C) 10446/2015, CM APPL. No. 26218/2015

GUDDU Petitioner

GOVT. OF NCT OF DELHI

versus

..... Respondent

+W.P.(C) 804/2016

SHAHEEN ANSARI Petitioner

versus

GOVT. OF NCT OF DELHI & ORS. Respondent

+W.P.(C) 2177/2016

SITA DEVI & ANR. Petitioners

versus

GOVT. OF NCT OF DELHI & ORS. Respondents

+W.P.(C) 5137/2016

ASHOK KUMAR Petitioner

versus

GOVT. OF NCT OF DELHI & ORS. Respondent
 + W.P.(C) 8827/2016
 CHINTA DEVI AND ANR. Petitioners

versus

GOVT OF NCT OF DELHI AND ORS. Respondents
 +W.P.(C) 9008/2016
 NISHA Petitioner

versus

GOVT. OF NCT OF DELHI & ORS. Respondents
 +W.P.(C) 10233/2016
 MAYA DEVI AND ANR. Petitioner versus
 GOVT OF NCT OF DELHI AND ORS. Respondent
 +W.P.(C) 509/2017
 DIVYA KUMRA Petitioner

versus

GOVT OF NCT OF DELHI AND ORS. Respondents
 +W.P.(C) 632/2017
 NASHRIN KHATUN Petitioner versus
 THE GOVT. OF NCT OF DELHI & ORS. Respondents

Present : Ms. Nair Pal with Ms. Pallavi Sharma and Mr. Deepak Kumar Singh, Advocates for petitioner in WP(C) Nos.10446/2015, 804/2016, 2177/2016, 5137/2016, 8827/2016, 9008/2016, 10233/2016, 509/2017 & 632/2017.
 Mr. Shatrajit Banarji, Adv. for Mr. Gautam Narayan, ASC for GNCTD in WP(C) No.10446/2015
 Mr. Sanjoy Ghose, ASC with Ms. Prathishthavij and Mr.Dhanjai Raina, Advocates for GNCTD/respondent in WP(C) Nos.804/2016, 2177/2016,

5137/2016 & 632/2017

Mr. Peeyoosh Kalra, ASC with Ms Sona Babbar, Advocate for GNCTD in WP(C) Nos.8827/2016 & 10233/2016

Mr. Devesh Singh, ASC for GNCTD in WP(C) No.9008/2016

Mr. Satyakam, ASC with Mr. Naveen Jakhar, Advocate for GNCTD in WP(C) No.509/2017

Mr. Amrit Pal Singh, Advocate for R-5 & R-6 (UOI) in WP(C) No.9008/2016

Mr. Vikram Jetly, CGSC for R-5 to R-7 (UOI) in WP(C) No.2177/2017

Mr. Parvinder Chauhan, Advocate for DUSIB in WP(C) Nos.2177/2016 & 5137/2016

Mr. Jasmeet Singh, CGSC for R-5 & R-6 (UOI) in WP(C) No.8827/2016

Mr. Vivek Goyal, CGSC with Ms Vanya Khanna, Advocate for UOI/R-5 & R-6 in WP(C) No.509/207

Mr. Kamal Kant Jha, Advocate for R-8 in WP(C) No.2177/2016

Mr. Manish Mohan, CGSC with Mr. Shivam Chanana, Ms. Manisha Saroha and Ms. Priyansha Sinha, Advocates for R-4 & R-5 in WP(C) No.10233/2016

Mr. G.D. Mishra, Advocate for R-3 in WP(C) No.632/2017

CORAM:

HON'BLE THE CHIEF JUSTICE

HON'BLE MS. JUSTICE SANG ITA DHINGRA SEHGAL

O R D E R

% 25.01.2017

W.P.(C) Nos.509/2017 & 632/2017

Mr. Satyakam, learned ASC for GNCTD accepted notice in W.P.(C) No.509/2017 and Mr. Sanjoy Ghose, the learned ASC for GNCTD accepted notice in W.P.(C) No.632/2017. The counter affidavits be filed within four weeks from today.

W.P.(C) Nos.10446/2015, 804/2016, 2177/2016, 5137/2016, 8827/2016, 9008/2016 & 10233/2016

Various issues relating to functioning of Anganwadi Centres in different zones of Delhi have been raised in this batch of petitions.

Pleadings be completed by all the parties before the next date of hearing.

We also request the learned Standing Counsel for GNCTD to prepare a chart specifying the relief sought in each writ petition so as to enable proper appreciation of the issues involved.

Shri Sanjoy Ghose, the learned ASC for GNCTD undertakes to file such chart in coordination with the other counsels appearing in the petitions. The same be filed within four weeks from today.

Re-notify on 04.05.2017.

CHIEF JUSTICE

JANUARY 25, 2017 / gr

SANGITA DHINGRA SEHGAL,

**Nirmal Gorana vs. Department Of Health and Family Welfare and Ors.
W.P. (C) 826/2018**

\$-61

*IN THE HIGH COURT OF DELHI AT NEW DELHI
+W.P.(C) 826/2018

% Date of decision : 29th January, 2018

NIRMAL GORANA

..... Petitioner

Through : Ms. Sija Nair Pal and
Mr. Deepak Kr. Singh, Adv.

versus

DEPARTMENT OF HEALTH AND FAMILY WELFARE AND ORS.

..... Respondents

Through : Mr. Sanjoy Ghose, Adv. for R-1 to 3 with Ms. Urvi Mohan, Adv.
Ms. Monika Arora, CGSC for R-UOI.

CORAM:

HON'BLE THE ACTING CHIEF JUSTICE
HON'BLE MR. JUSTICE C.HARI SHANKAR
JUDGMENT (ORAL)

GITA MITTAL, ACTING CHIEF JUSTICE

1. This writ petition contends that the Anganwadi Centres in the Badarpur area of Delhi are being deprived of the benefits of the Integrated Child Development Scheme (ICDS) and the

other schemes of the Government for the reason that the Government of NCT of Delhi has been unable to deploy ASHA workers. The second grievance expressed in the writ petition is that the ASHA Workers are not effectively implementing the other ICDS schemes. As a result, the residents of this area are being deprived of the key maternal and child related healthcare schemes under the National Health Mission, 2015 including the Janani Suraksha Yojana (JSY), 2005; Janani Shishu Suraksha Karyakaram (JSSK), 2011 and ICDS scheme, 1975.

1. Appearing on advance notice, Mr. Sanjoy Ghose, Addl. Standing Counsel for the Govt. of NCT of Delhi informs this court that the respondent nos. 1 to 3 are aware of the urgency of the matter and that despite best efforts, it has not been able to recruit trained ASHA workers for the Bhat Camp with regard to which the petitioner has made a grievance. Mr. Ghose informs us that earnest efforts in this regard are underway and that the steps to recruit trained ASHA workers wheresoever needed would be expeditiously completed. It is submitted by Mr. Ghose that the respondents are conscious of their responsibilities and for this reason, ASHA Workers from other areas of Badarpur are being diverted to the Bhat Camp to ensure that no citizen suffers in any manner.

We take this statement on record. It is expected that the respondent nos. 1 to 3 shall undertake the needful within a period of three months from today.

2. The respondents shall also ensure that the grievance regarding implementation of the other ICDS Schemes including the immunization programmes is looked into, examined and appropriate steps in this regard are taken immediately.
3. This writ petition is disposed of in the above terms.

Dasti.

ACTING CHIEF JUSTICE

C.HARI SHANKAR, J

न्यायमेव जयते

Rosemary vs State of Nagaland W. P. (C) No 8 (K) /2018

Date of application for the copy.	Date fixed for notifying the requisite number for stamps and folios.	Date of delivery of requisite stamps and folios.	Date on which the copy was ready for delivery.	Date of making over to the applicant.
11-06-19	11-06-19	11-06-19	12-06-19	12-06-19

IN THE GAUHATI HIGH COURT
(HIGH COURT OF ASSAM;NAGALAND;MIZORAM & ARUNACHAL PRADESH)
KOHIMA BENCH

P.I.L. NO. 8(K) of 2018

Dr. Rosemary Dzuvichu .. Petitioner
Vs
The State of Nagaland & 7 Ors. .. Respondents

PRESENT
THE HON'BLE MR. JUSTICE MIR ALFAZ ALI

For the Petitioner : K. Kikhi
P.N. Phom
Neiteo Koza
Pakinrichapbo
Advs.

For the Respondent : Govt. Adv. Nagaland
Yangervati, Adv. for R/No.8.
N.Mozhui
K. Kire
L. Likhase
Apila Sangtam
Naomy Sale
N. Rupreo
For R/Nos. 2 & 3.

10.06.2019

ORDER

Learned counsels for the parties are in attendance.

Learned counsel for the respondents No. 2 & 3 prays for three weeks time to file counter affidavit.

The prayer is allowed.

List this matter after three weeks.

Certified to be true Copy
MJ
12/06/2019
Deputy Registrar (Judl.)
Gauhati High Court
Kohima Bench
Authorised U/S 76 ACT 1 of 1872

Sd/- JUDGE



Budhinath Girisa vs State of Nagaland W.P. (C) No 9 (K) /2018

Date of application for the copy.	Date fixed for notifying the requisite number for stamps and folios.	Date of delivery of requisite stamps and folios.	Date on which the copy was ready for delivery.	Date of making over to the applicant.
25-05-19	25-05-19	25-05-19	30-05-19	23-06-19

IN THE GAUHATI HIGH COURT
(HIGH COURT OF ASSAM:NAGALAND:MIZORAM & ARUNACHAL PRADESH
KOHIMA BENCH)

**P.I.L. NO. 35 (K) of 2017**

Odi Jamir & Anr. .. Petitioner
Vs
The State of Nagaland & Ors. .. Respondents

P.I.L. NO. 2 (K) of 2018

Mr. Tahie Konyak .. Petitioner
Vs
The State of Nagaland & 6 Ors. .. Respondents

P.I.L. NO. 3 (K) of 2018

Kiumukam .Y & Anr. .. Petitioner
Vs
The State of Nagaland & 6 Ors. .. Respondents.

P.I.L. NO. 5 (K) of 2018

Yantsow N. Ezung .. Petitioner
Vs
The State of Nagaland & 6 Ors. .. Respondents.

P.I.L. NO. 7 (K) of 2018

Shri Zuchanthung C. Kikon .. Petitioner
Vs
The State of Nagaland & 6 Ors. .. Respondents.

P.I.L. NO. 9 (K) of 2018

Mr. Budhinath Girisa .. Petitioner
Vs
The State of Nagaland & 9 Ors. .. Respondents.

P.I.L. NO. 23 (K) of 2017

Dr. Rosemary Dzuwichu .. Petitioner
Vs
The State of Nagaland & 6 Ors. .. Respondents.

P.I.L. NO. 24 (K) of 2017

Shri Chawangbo Changlungmai .. Petitioner
Vs
The State of Nagaland & 6 Ors. .. Respondents.



Shri Chawangbo Chalummai
Vs
The State of Nagaland & 5 Ors.

P.I.L. NO. 26 (K) of 2017
Petitioner
Respondents.

Odi Jamir & Anr.
Vs
The State of Nagaland & 6 Ors.

P.I.L. NO. 27 (K) of 2017
Petitioner
Respondents.

Marina
Vs
The State of Nagaland & 7 Ors.

P.I.L. NO. 28 (K) of 2017
Petitioner
Respondents.

Mr. Joe Dzucichu
Vs
The State of Nagaland & 6 Ors.

P.I.L. NO. 29 (K) of 2017
Petitioner
Respondents.

Mr. Langshie
Vs
The State of Nagaland & 7 Ors.

P.I.L. NO. 30 (K) of 2017
Petitioner
Respondents.

Shri Chumben Yanthan
Vs
The State of Nagaland & 6 Ors.

P.I.L. NO. 31 (K) of 2017
Petitioner
Respondents.

Odi Jamir & Anr.
Vs
The State of Nagaland & 6 Ors.

P.I.L. NO. 32 (K) of 2017
Petitioner
Respondents.

Shri Nyemkup
Vs
The State of Nagaland & 7 Ors.

P.I.L. NO. 33 (K) of 2017
Petitioner
Respondents.

Shri Chumben Yanthan
Vs
The State of Nagaland & 6 Ors.

P.I.L. NO. 34 (K) of 2017
Petitioner
Respondents.

Shri Mukam
Vs
The State of Nagaland & Ors.

P.I.L. NO. 36 (K) of 2017
Petitioner
Respondents.





P.I.L. NO. 37 (K) of 2017

Shri Joe Dzuvichu .. Petitioner
 Vs ..
 The State of Nagaland & Ors. .. Respondents.

P.I.L. NO. 38 (K) of 2017

Shri Odi Jamir & Anr. .. Petitioner
 Vs ..
 The State of Nagaland & 6 Ors. .. Respondents.

P.I.L. NO. 39 (K) of 2017

Shri Zuchanthung C. Kikon .. Petitioner
 Vs ..
 The State of Nagaland & 6 Ors. .. Respondents.

PRESENT

THE HON'BLE MR. JUSTICE MICHAEL ZOTHANKHUMA
THE HON'BLE MR. JUSTICE MANISH CHOUDHURY

For the Petitioner : K. Kikhi
 L. Chuba
 Pakinrichapbo
 Advs.

For the Respondent : Govt. Adv. Nagaland
 Yangerwati, CGC for R/No.7
 N. Mozhui, Adv. for R/No.4.

27.05.2019
(Michael Zothankhuma, J)

ORDER

Mr. N. Mozhui, learned counsel for the respondents submits that he will be filing affidavit-in-opposition within 2 (two) days.

List the matter **after a week.**

In the meantime, the petitioners may file their affidavit-in-reply.

Certified to be true Copy

Sd/- JUDGE

Sd/- JUDGE

MJ
20/05/19

Deputy Registrar (Judl.)
Gauhati High Court
Kohima Bench
Authorised U/S 76 ACT 1 of 1872

HYGIENE AND SANITATION**Mohd. Saleem V. Delhi Urban Shelter Improvement Board and Others
W.P No 10827/2016**

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* IN THE HIGH COURT OF DELHI AT NEW DELHI
+ W.P.(C) 10827/2016

MOHD. SALEEM

..... Petitioner

Through: Ms. Pallavi Sharma & Ms. Sija Nair Pal, Advs.

Versus

DELHI URBAN SHELTER IMPROVEMENT BOARD & ORS

..... Respondents

Through: Mr. Naushad Ahmed Khan, ASC, Civil, GNCTD/R-1 & 2.

Mr. Manish Mohan, CGSC with Mr. Shivam Chanana & Ms. Manisha Saroha, Advs. for UOI. Ms. Mini Pushkarna, Standing Counsel, DUSIB with Ms. Namrata Mukim, Ms. Anushruti & Ms. Vasundhara Nayyar, Advs. for DUSIB.

Mr. Siddharth Nagpal for Mr. Sumeet Pushkarna, Standing Counsel, DJB for DJB.

CORAM:

HON'BLE THE CHIEF JUSTICE

HON'BLE MS. JUSTICE SANGITA DHINGRA SEHGAL

O R D E R

% 20.01.2017

Ms. Mini Pushkarna, the learned Standing Counsel who appeared for DUSIB, on instructions, states that in terms of the order dated 17.08.2016 passed by this Court in W.P.(C) No.7245/2016, steps have already been initiated for providing toilet facilities in various *jhuggies jhoperi* clusters in Delhi.

W.P.(C) No.10827/2016

Page 1 of 2

It is stated that the petitioner was already informed of the steps taken vide letter dated 26.09.2016. A copy of the said letter has been furnished to the learned counsel for the petitioner today.

An affidavit be filed by the respondent No.1 within two weeks from today explaining the steps stated to have been taken. Rejoinder, if any, by the petitioner within two weeks thereafter.

Call on 07.03.2017.

CHIEF JUSTICE

SANGITA DHINGRA SEHGAL, J

JANUARY 20, 2017

kks

Continued...

§-16

* IN THE HIGH COURT OF DELHI AT NEW DELHI

+ W.P.(C) 10827/2016

MOHD. SALEEM

..... Petitioner

Through: Ms. Pallavi Sharma with Mr.
Deepak Kumar Singh, Advs.

versus

DELHI URBAN SHELTER IMPROVEMENT BOARD & ORS

..... Respondent

Through: Ms. Mini Pushkarna with
Ms. Vasundhara Nayyar and Ms. Anushruti, Advs. for R- 1.
Mr. Sahil Ghai, Adv. for Mr. Sumeet Pushkarna, Adv. for R-2.

CORAM:

HON'BLE THE ACTING CHIEF JUSTICE

HON'BLE MS. JUSTICE PRATHIBA M. SINGH

O R D E R

% 19.05.2017

1. This writ petition complains with regard to lack of sanitation and toilet facilities in J.J. Cluster. An affidavit has been filed by the respondent No.1 Delhi Urban Shelter Improvement Board disputing the petitioner's contentions.

2. The writ petition has been filed in public interest which purpose would be served if the respondents inform this Court with regard to the status of sanitation and toilet facilities in all the J.J. Clusters.

We, therefore, direct the respondent No.1 Delhi Urban Shelter Improvement Board, which is concerned with these issues to file an affidavit by an highest authority stating the following details:

- (i) Number of J.J. Clusters;
- (ii) Population of J.J. Clusters;
- (iii) Availability and number of toilets provided in J.J. Clusters; and
- (iv) Availability of running water and usability in J.J. Clusters.

3. Such affidavit shall be filed within four weeks from today.

4. We make it clear to the parties that this Court would in random inspect to verify the facts stated in the affidavit on the next date of hearing.

5. The petitioner shall file an affidavit giving the details of the houses referred in para 14 of the writ petition.

7. List on 11.07.2017.

ACTING CHIEF JUSTICE
PRATHIBA M. SINGH, J

MAY 19, 2017/pmc

Manickchand Vs SDMC& Ors. W.P No 1023/2017

§~41.

* IN THE HIGH COURT OF DELHI AT NEW DELHI

+ W.P.(C) 1023/2017

MANIKCHAND

..... Petitioner

Through: Mr. Fidel Sebastian, Adv. with
Mr. Deepak Kumar Singh, Adv.

Versus

SOUTH DELHI MUNICIPAL CORPORATION AND ORS

..... Respondents

Through: Mr. Parvinder Singh Chauhan, Adv. with
Mr. Nitin Jain, Adv. for R-2/DUSIB.
Mr. Sumeet Pushkarna, Adv. for R-3/DJB.

CORAM:

HON'BLE THE CHIEF JUSTICE

HON'BLE MS. JUSTICE SANGITA DHINGRA SEHGAL

06.02.2017

Mr. Parvinder Chauhan, the learned counsel accepted notice for respondent No.2/DUSIB and Mr. Sumeet Pushkarna, the learned counsel accepted notice for respondent No.3/DJB.

Issue notice to the respondent No.1.

Renotify on 17.05.2017. Response, if any, on behalf of respondents No.2 and 3 be filed within four weeks.

CHIEF JUSTICE

SANGITA DHINGRA SEHGAL, J

FEBRUARY 06, 2017

'anb'

Continued...

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*IN THE HIGH COURT OF DELHI AT NEW DELHI
+ W.P.(C) 1023/2017

MANIKCHAND

..... Petitioner

Through: Ms. Pallavi Sharma, Adv.

versus

SOUTH DELHI MUNICIPAL CORPORATION AND ORS.

.... Respondent

Through: Mr. Rakesh Mittal, SC for
SDMC with Mr. Kamlesh Anand & Ms. Yamini Mittal, Adv.for R-1
Mr. Parvinder Chauhan, Mr. Nitin Jain, Adv. with Mr.
S.K. Varshney(EE-DUSIB) for R-2/DUSIB

CORAM:

HON'BLE THE ACTING CHIEF JUSTICE
HON'BLE MR. JUSTICE NAVIN CHAWLA

O R D E R

% 17.05.2017

Learned counsel for the respondents pray for time to file counter affidavits. Let the same be filed within six weeks from today. Rejoinders thereto, if any, be filed before the next date.

List on 23rd August, 2017.

ACTING CHIEF JUSTICE
NAVIN CHAWLA, J

MAY 17, 2017/kr

Continued....

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*IN THE HIGH COURT OF DELHI AT NEW DELHI
+W.P.(C) 1023/2017

MANIKCHAND

..... Petitioner

Through : Mr. Deepak Kumar Singh and
Ms. Pallavi Sharma, Advs.

versus

SOUTH DELHI MUNICIPAL CORPORATION AND ORS

..... Respondents

Through : Ms. Puja Kalra, Adv. for
Mr. Rakesh Mittal, Adv. for R- 1.
Mr. Kamal Kant Jha, Adv. for R-3/Delhi Jal Board.

CORAM:

HON'BLE THE ACTING CHIEF JUSTICE
HON'BLE MR. JUSTICE C.HARI SHANKAR

O R D E R

% 23.08.2017

1. In view of the counter affidavit of DUSIB – respondent no.2 (at page 296), response of South Delhi Municipal Corporation – respondent no.1 and Delhi Jal Board – respondent no.3 is necessary. Let respondent nos.1 and 3 file their counter affidavits within four weeks from today. Rejoinders thereto, if any, be filed before the next date of hearing.
2. List on 16th November, 2014.

ACTING CHIEF JUSTICE

C.HARI SHANKAR, J

AUGUST 23, 2017

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Continued...

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*IN THE HIGH COURT OF DELHI AT NEW DELHI
+W.P.(C) 1023/2017

MANIKCHAND Petitioner

Through: Ms. Sija Nair Pal with Mr. Deepak
Kumar Singh, Advs. versus

SOUTH DELHI MUNICIPAL CORPORATION AND ORS Respondent

Through: Mr. Rakesh Mittal, Standing Counsel with
Mr. Kamlesh Anand and Yamini Mittal, Advs. for SDMC.
Mr. Kamal Kant Jha, Adv. for Delhi Jal Board.

CORAM:

HON'BLE THE ACTING CHIEF JUSTICE
HON'BLE MR. JUSTICE C.HARI SHANKAR

O R D E R

% 16.11.2017

1. Counter affidavit stands filed on behalf of the respondent No.2.
2. Let the respondent Nos.1 and 3 also file their counter affidavits within three weeks from today.
3. Rejoinders thereto, if any, be filed before the next date of hearing.

List on 22nd February, 2018.

ACTING CHIEF JUSTICE

C.HARI SHANKAR, J

NOVEMBER 16, 2017/pmc

Continued...

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* IN THE HIGH COURT OF DELHI AT NEW DELHI

+ W.P.(C) 1023/2017 MANIKCHAND

..... Petitioner

Through: None versus

SOUTH DELHI MUNICIPAL CORPORATION AND ORS

..... Respondent

Through: Mr. Rakesh Mittal standing Counsel for South Delhi Municipal Corporation
with Ms. Yamini Mittal, Advs. ,Mr. Kamal Kant Jha, Adv. , Mr. Siddharth
Jha, Adv. , Mr. Prabhakar Thakur, Adv. and Mr. Krishna Kumar, Adv. for
Respondent DJB

O R D E R

% 21.01.2019

The Hon'ble Division Bench-I (Coram: Hon'ble the Chief Justice and HMJ V.Kameswar Rao)
could not assemble today.

List on 01.04.2019.

BY ORDER
(COURT MASTER)

JANUARY 21, 2018

**Nirmal Gorana Vs South Delhi Municipal Corporation and Others W.P.
(C) 8891/2017**

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*IN THE HIGH COURT OF DELHI AT NEW DELHI
+W.P.(C) 8891/2017

NIRMAL GORANA

..... Petitioner

Through : Ms. Pallavi Sharma and
Mr. Deepak Kr. Singh, Adv.

versus

SOUTH DELHI MUNICIPAL CORPORATION AND ORS

. Respondents

Through : Mr. Swastik Singh, Adv. for
R-1/SDMC
Mr. P. Chauhan, Adv. for R-2

CORAM:

HON'BLE THE ACTING CHIEF JUSTICE
HON'BLE MR. JUSTICE C.HARI SHANKAR

O R D E R

% 10.10.2017

1. Issue notice to the respondents to show cause as to why rule nisi be not issued, returnable on 24th January, 2018.

2. Mr. Swastik Singh, learned counsel accepts notice on behalf of the respondent no.1.
3. Mr. P. Chauhan, learned counsel accepts notice on behalf of the respondent no.2.
4. The respondent nos. 1 and 2 shall conduct a spot inspection before filing the counter affidavits. Counter affidavits/status report shall be filed within six weeks from today. Rejoinder thereto, if any, be filed before the next date.
5. Subject to the petitioner taking steps, notice shall issue for the service of the respondent no. 3, returnable on 24th January, 2018. Notice issued to respondent no.3 shall indicate that a status report/counter affidavit shall be filed within five weeks of the receipt of the notice.
6. List on 24th January, 2018.

ACTING CHIEF JUSTICE

C.HARI SHANKAR, J

OCTOBER 10, 2017/kr

Setu Niket vs Union of India and ORS W.P. (C) 5909/2017

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* IN THE HIGH COURT OF DELHI AT NEW DELHI
+ W.P.(C) 5909/2017, C.M. Appl. No. 43147/2018 (Delay)

SETU NIKET

Petitioner

Through: Ms. Rushila Revello,
Ms. S.B. Mohanty, Advocate

versus

UNION OF INDIA AND ORS

Respondent

Through: Mr. Dev P. Bhardwaj, CGSC with Ms. Anubha Bhardwaj, Advocate for
UOI, respondent No. 1.
Ms. Esha Mazumdar, Advocate for respondent No. 2.
Mr.Kumar Vikram, Advocate for respondent No. 9
Mr.Anil Grover, Standing Counsel, New DMC with Mr. Mishal Vij,
Advocate
Ms. Monika Arora, with Mr. Harsh Ahuja, Mr. Kushal Kumar, Advocate
for respondent No. 7 (SDMC)
Mr. Rajeev Sharma, Mr. Atul Tyagi, Advocate for respondent No. 4
Mr. Sanjoy Ghose, Additional Standing Counsel for Govt. of NCT of
Delhi with Ms. Urvi Mohan, Advocate

CORAM:

HON'BLE MR. JUSTICE G.S.SISTANI
HON'BLE MS. JUSTICE JYOTI SINGH

O R D E R

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13.08.2019

On 13th March 2018, on an application filed by Ms. Shaoni Mukherjee, this court had permitted her to make submissions in the writ petition without being impleaded as a party. Today, a report has been handed over in court on behalf of Ms. Shaoni Mukherjee. On examination of this report, we are of the view that Ms. Shaoni Mukherjee would be a necessary and proper party as her contribution would help to serve the cause of this writ petition. Accordingly, with the consent of the parties, we modify the order of 13th March 2018 and implead Ms. Shaoni Mukherjee as petitioner no.2. Let amended memo of parties be filed. Let the report be filed on record, after supplying a copy thereof to counsel for the opposite side.

The present petition has highlighted the lack of knowledge regarding Menstruation and Menstrual Hygiene and sensitisation of the same, in adolescent girls in schools run by the Govt. of NCT of Delhi and by the Corporations. We are informed that the Delhi Government has a scheme in the name of UDAAN which was rolled out on 3rd April 2019 under which adolescent girls are provided sanitary napkins by Accredited Social Health Activists (ASHAs) at a subsidised rate of Rs.6/-.

Mr. Ghosh also submits that since its inception, the scheme has been availed by more than 45000 non-school going adolescent girls on regular monthly basis. The government has purchased 14.4 lakhs sanitary napkins which approximately costs Rs.28 lakhs and another supply of 9 lakhs sanitary napkin is in the pipeline which would be received in the stores between 13th to 16th August 2019. However, there is no specific information as to whether they have been received by now or not. We are also informed by Mr. Ghosh that nearly 42,700 adolescent girl have been educated during the first quarter of the current financial year 2019-2020 about the standard practice in menstrual hygiene in a healthy manner and for maintaining of personal hygiene removing various doubts and misconceptions.

Mr. Ghosh has also drawn the attention of the court to the affidavit filed by Directorate of Education wherein it has been stated that in all schools run by the Delhi Government under the Kishori Yojana, the girls have been provided with Sanitary Napkins free of cost.

Although some material has been placed before us, but we find that there are no details as to the number of schools under the Delhi Government, under the New Delhi Municipal Committee and under the South, East and North Delhi Municipal Corporation. We also request the Departments to provide the break-up of number of schools which are co-educational and schools which are meant only for girls. We also direct the respondents to provide information as to whether any common circular has been issued to all the Heads of the Institutions and as to whether a Power Point Presentation or any material has been circulated so that there is uniformity in information being transmitted to the children. This we say for the reason that in case there are different programmes and there are differences in the form of education, two children who may not belong to same school, may be left confused as to the different information supplied to them. The aim and object of the schemes should be first to educate the children, remove their doubts and educate them about

the reasons and the importance of their personal hygiene. While imparting this education, every effort should be made to ensure the privacy of the children. The access to the sanitary napkins should also be in such a way that a child may not get embarrassed. At least once, in two weeks, the children should be updated and interactive session should be held allowing them to interact with the teachers/counsellors so that their queries can be answered. The circulars, if not issued, should be issued within four weeks. Similarly, counsellors, if not appointed, should be appointed within four weeks. The Power Point Presentation of the common matter, which is to be shared with the student should be prepared and uniformly circulated.

Let the affidavits be filed within six weeks positively. The affidavit should also disclose the number of toilets, exclusively for girls, in co-educational institutions across the board.

A copy of this order be served on Ms. Mini Pushkarna, counsel for SDMC, to enable the South Delhi Municipal Corporation to respond and also to appear in the matter.

List for further hearing on 18th October 2019. Dasti

G.S.SISTANI, J

JYOTI SINGH, J

AUGUST 13, 2019

pkb

LACK OF ESSENTIAL MEDICINE**Union of India and Anr. Pfizer Limited and Ors Civil Appeal No. 22972 of 2017 (arising Out Of Slp (C) No.7061 Of 2017)**

IN THE SUPREME COURT OF INDIA
CIVIL APPELLATE JURISDICTION
CIVIL APPEAL NO. 22972 OF 2017
(ARISING OUT OF SLP (C) NO.7061 OF 2017)

UNION OF INDIA AND ANR.
PFIZER LIMITED AND ORS.

...APPELLANTS
...RESPONDENTS

VERSUS

WITH
(ARISING OUT OF SLP (C) NO.10170-10178 OF 2017)
CIVIL APPEAL NOS. 22973-22981 OF 2017

CIVIL APPEAL NOS. 22982-23404 OF 2017
TRANSFERRED CASE (C) NO.30 OF 2017
(ARISING OUT OF SLP (C) NO.28960-29382 OF 2017)

TRANSFERRED CASE (C) NO.29 OF 2017
TRANSFERRED CASE (C) NO.31 OF 2017

Signature Not Verified

TRANSFERRED CASE (C) NO.32 OF 2017

TRANSFERRED CASE (C) NO.33 OF 2017

TRANSFERRED CASE (C) NO.34 OF 2017

TRANSFERRED CASE (C) NO.35 OF 2017

TRANSFERRED CASE (C) NO.39 OF 2017

Digitally signed by

VISHAL ANAND

Date: 2017.12.15

17:00:27 IST

Reason:

TRANSFERRED CASE (C) NO.36 OF 2017

1

TRANSFERRED CASE (C) NO.38 OF 2017

TRANSFERRED CASE (C) NO.258 OF 2017

TRANSFERRED CASE (C) NO.40 OF 2017

TRANSFERRED CASE (C) NO.41 OF 2017

TRANSFERRED CASE (C) NO.42 OF 2017

TRANSFERRED CASE (C) NO.43 OF 2017

TRANSFERRED CASE (C) NO.44 OF 2017

TRANSFERRED CASE (C) NO.45 OF 2017

TRANSFER PETITION (C) NOS.1176-1182 OF 2017

TRANSFERRED CASE (C) NO.266 OF 2017

TRANSFERRED CASE (C) NO.259 OF 2017

TRANSFERRED CASE (C) NO.260 OF 2017

TRANSFERRED CASE (C) NO.261 OF 2017

TRANSFERRED CASE (C) NO.262 OF 2017

TRANSFERRED CASE (C) NO.263 OF 2017

TRANSFERRED CASE (C) NO.264 OF 2017

TRANSFERRED CASE (C) NO.265 OF 2017

CIVIL APPEAL NOS. 23405-23472 OF 2017

JUDGMENT

(ARISING OUT OF SLP (C) NOS. 36044-36111 OF 2017

Diary No.28274 of 2017

2

TRANSFERRED CASE (C) NOS. 308-317 OF 2017

(ARISING OUT OF T.P. (C) NOS.2108-2117 OF 2017)

R.F. Nariman, J.

1. Leave granted.
2. The present appeals and transfer petitions relate to the interpretation of Section 26A of the Drugs and Cosmetics Act, 1940 (hereinafter referred to as “the Drugs Act”). By the impugned judgment of the learned single Judge of the Delhi High Court dated 1.12.2016, the learned single Judge has held that the mandatory condition precedent for the exercise of the power by the Central Government under Section 26A of the Drugs Act is the prior consultation of the Drugs Technical Advisory Board (DTAB) set up under Section 5 of the said Act.

It must be stated that the learned single Judge differed from judgments of the Karnataka and Madras High Courts in this regard, wherein two other learned single Judges of two other High Courts have held that such consultation with the DTAB is not mandatory before exercise of such power under Section 26A. Since we are concerned only with this narrow question that has been decided by the learned single Judge of the Delhi High Court, we are not going into any other contentions that have been raised by learned counsel for the parties.

3. The issue regarding the prevalence of many Fixed Dose Combinations (hereinafter referred to “FDCs”) that were flooding the Indian market and had not been tested for efficacy or safety was considered by the Parliamentary Standing Committee on Health and Family Welfare in its 59 th Report in May, 2012. The Standing Committee observed that some of the State Licensing Authorities have issued manufacturing licenses for a very large number of FDCs without prior clearance from the Central Drugs Standard Control Organization (CDSCO). Such FDCs can pose significant risks to persons and need to be withdrawn immediately in that human lives can be at risk. The Committee recommended that a clear and transparent policy may be framed for approving FDCs based on scientific principles, and that, at present, Section 26A of the Drugs Act is adequate to deal with the problem of FDCs not cleared by the CDSCO. Pursuant to the aforesaid report, the Ministry of Health in October, 2012 issued directions to States and Union Territories under Section 33P of the Drugs Act not to grant licenses to FDCs falling under the definition of “new drugs” and not approved by the Drug Controller General of India (DCG(I)). The DCG(I), in turn, had requested all States/Union Territories Drug Controllers to ask concerned manufacturers in their respective States/Union Territories to prove the safety and efficacy of such FDC licenses issued prior to 1.10.2012, without due approval of the

DCG(I), within a period of 18 months, failing which such FDCs would be considered for being prohibited, both qua manufacture and marketing in the country. On 5.7.2013, the DCG(I) vide its communication to the State Drug Controllers asked manufacturers to make applications as per the procedure prescribed within this 18 month period. We have been informed that a large number of applications were received from the manufacturers within the 18 month period for 2911 products, which had to be subjected to examination.

4. With the approval of the Ministry of Health and Family Welfare, the CDSCO constituted 10 different Committees for examination of the said applications which were received on 3.2.2014. As the said Committees could examine only about 295 applications, on 16.9.2014, the Ministry of Health and Family Welfare constituted a Committee under the Chairmanship of Professor C.K. Kokate, Vice Chancellor of KLE University, Belgaum, Karnataka for examining the safety and efficacy as per the following terms of reference:
 - a. Those FDCs which are considered grossly irrational/unsafe based on pharmacokinetic and pharmacodynamic interaction, dosage compatibilities of FDCs vis-a-vis that of single ingredients present in the FDC and available literature/evidence.
 - b. Those FDCs which the Committee may consider necessary for further deliberation with any of the 10 Expert Committees already constituted.
 - c. Those FDCs which are considered as safe and effective based on pharmacokinetic and pharmacodynamic interaction, dosage compatibilities of FDCS vis-a-vis that of single ingredients present in the FDC, available literature/evidence, clinical experience and other data available.
 - d. Those FDCs which may be considered as rational, based on present data and knowledge available. However, data in post market scenario is required to be generated within a period of 1 to 2 years to confirm the same.
 - e. All the FDCs falling, under category “b” above would be referred to the respective Expert Committee out of 10 Expert Committees already constituted.

Composition of Expert Committee for examining the safety & efficacy of Fixed Dose Combinations (FDCs) is as under:

S.No.	Name of Expert	Name & Address	Qualification	Status in the of on Committee
1.	Prof. Vice-Chancellor, M. Pharm, Chairman Institutions	Chandrakant KLE University, Ph.D.		
	Ex-President of Kokate Belgaum, Karnataka & Pharmacy			

NIPER, 432, Ph.D.

Council of India.

2. Dr. C.L. Kaul Former Director, B. Pharm, Member
Mahatma
Singh Pharmaceuticals, Ph.D.
Society, Koth
Road, Pune-38.
3. Prof. Sanjay Deptt. of M. Pharm, Member
IIT, BHU,
Safdarjung ogy
Varanasi.
4. Dr. C.D. Prof. & HOD MD, Member
Tripathi (Pharmacology), Pharamacol
Hospital, New
Chandigarh.
Delhi.
5. Dr. Bikash Deptt. of MD, Member
Medhi Pharmacology, Pharmacolo
PGIMER, gy
Head, Jamia Ph.D. Member
6. Dr. Sanjeev Prof. (Medicine), MD, Member
Sinha AIIMS, New Delhi Medicine
7. Dr. R.K. Khar Former Dean & M. Pharm, Co-opted
Hamdard,
403, Lalleshwari
Vatika, GH-12,
Sector-21D,
Faridabad-1210

A series of meetings were conducted by the Committee (6 meetings corresponding to 11 days) as well as by a sub-group of the Committee (2 meetings) for examination of these approx. 6320 applications.

5. The first assessment report of the aforesaid Committee was submitted to the Ministry of Health and Family Welfare on 19.1.2015 and was presented before the Ministry on 4.3.2015, wherein the Committee was requested to mention detailed reasons against each FDC considered as “irrational” by the Committee. The Committee did not discuss FDCs already approved by the DCG(I) and FDCs which were licensed pre 21.9.1988 i.e. before the introduction of Schedule Y to the Drugs Act. The Committee stated, “in case the Committee made any comment with respect to the above inadvertently, it shall be treated as not discussed.”
6. On 16.4.2015, a detailed report in this regard was submitted by the Kokate Committee to the Ministry stating the reasons for declaring FDCs as irrational. We have been informed that for the FDCs which were considered as irrational by the Committee, the Committee wrote to various manufacturers/associations calling upon them to submit material to establish the therapeutic justification/rationality of the FDCs. Replies received from such associations were examined by the Expert Committee and final recommendations therein were given only on 10.2.2016. In category A, following the final recommendations of the Expert Committee, the Central Government has banned 344 FDCs. In category B, 944 FDCs needed to be considered/ deliberated upon further, which meant that they would be referred to the respective Expert Committees out of the 10 Expert Committees already constituted for further examination. In category C, 1493 FDCs have been declared “rational” and we are informed that approvals have since been issued by the DCG(I) in respect of these FDCs. In category D, 126 FDCs have to be considered for further generation of data by the prospective applicants. It is only after carrying out of this exercise, that by notifications dated 10.3.2016 issued under Section 26A, the Central Government banned manufacture and sale of 344 FDCs.
7. In March 2016, a large number of writ petitions were filed in the Delhi High Court against the aforesaid notifications. The impugned judgment then followed on 1.12.2016 disposing of 454 petitions, followed by an order dated 21.12.2016, in which the Delhi High Court disposed of 51 further writ petitions in terms of the judgment dated 1.12.2016.
8. Letters Patent Appeals were filed before the Delhi High Court. Meanwhile, the Union of India filed transfer petitions in this Court. This is how these matters have been heard by us in civil appeals arising out of SLPs against the judgment of the single Judge dated 1.12.2016 and in transfer cases in which the LPAs pending before the Delhi High Court have been transferred to us.
9. Ms. Pinky Anand, learned Additional Solicitor General, took us through various provisions of the Drugs Act, and emphasized that Section 26A does not expressly refer to the DTAB. According to her, a large number of provisions of the Drugs Act expressly refer to the DTAB in various contexts and, therefore, it is not permissible for the Court to read a mandatory requirement of consultation with the DTAB into Section 26A, when such mandatory consultation is present in other provisions, but is conspicuous by its absence in Section 26A.

She further went on to state that the provisions of Section 26A are legislative in nature, and

ultimately, once the Central Government arrives at a satisfaction based on relevant materials, judicial review of the Central Government decision taken on the basis of Expert Committee reports is extremely limited. She launched an all out attack against the single Judge's judgment and stated that the Madras and Karnataka view, with which the Delhi High Court differed, is the correct view in law. Shri Colin Gonsalves, learned senior counsel, supported her arguments, and appeared in civil appeal arising out of SLP(C) Nos.10170-10178 of 2017.

10. By way of reply, Shri C.S. Vaidyanathan, learned senior counsel, argued that the impugned single Judge judgment was based on an earlier Division Bench judgment in E. Merck (India) Ltd. and another v. Union of India and another, (2001) 90 DLT 60, which upheld the constitutional validity of Section 26A on the ground that since the DTAB had to be consulted before passing an order under Section 26A, the said Section would pass constitutional muster. He also referred us to this Court's judgment in Systopic Laboratories (Pvt) Ltd. v.

Dr. Prem Gupta & Ors., 1994 Supp (1) SCC 160 in furtherance of the same proposition. According to learned counsel, it is clear on a reading of Section 5 of the Drugs Act, that it will apply to both the Central Government and the State Governments on all technical matters that arise out of the administration of the Drugs Act. Since Section 26A deals only with such technical matters, it is obvious that the DTAB's advice has to be taken in every such case as otherwise, if it were open to the Central Government to pick and choose in which case they would take such advice and which case they would not take such advice, the provision itself would become arbitrary and unreasonable. According to the learned senior counsel, Section 5(5) of the Drugs Act is very important in that it is the DTAB alone who may constitute sub-committees consisting of persons who are not members of the DTAB, who may consider particular matters, thereby making it clear that the DTAB alone can induct experts who are outside Section 5 and not the Central Government. He further referred to the Drugs and Cosmetics Rules, 1945 (hereinafter referred to as the "Drugs Rules"), in particular Rules 21, 68A, 122A, 122D and 122DA, to buttress his submission that a detailed filtration process has to be gone through before a drug can be manufactured and put on the market and that the Central Government cannot ban such drug without consulting the technical expert under the Drugs Act namely, the DTAB, that is set up under Section 5. He also argued that Sections 10A and 26A were introduced by way of an amendment in 1982 and this being so, it is clear that it is assumed by Parliament that Section 5 of the Drugs Act will be read along with both of them so as to make the DTAB a mandatory consultee before action is taken under Section 26A.

11. Shri Vashisht, learned senior counsel appearing for some of the respondents, adverted to Section 5 and stated that it was in two parts, the first being advice to the Central Government on all technical matters arising out of the administration of the Drugs Act and the second (and distinct part) being to carry out other functions assigned to it by the Drugs Act. It is clear, therefore, that in all matters which fall within the first part, the advice of the Board would be mandatory before the Central Government were to take action under Section 26A. He also referred us to Section 7A of the Drugs Act and argued that when the said Drugs Act expressly

states that nothing in Section 5 is to apply, it is expressly so stated and that, therefore, the necessary inference would be that Section 5 would apply in all situations other than those covered by Section 7A. He further argued that Section 26A does not have a non obstante clause which puts out of harm's way Section 5, but only a "without prejudice" clause and that too restricted only to Chapter IV, making it clear that Section 26A would have to be read along with Section 5. According to him, therefore, there is no reason to interfere with the judgment of the Delhi High Court.

12. Dr. A.M. Singhvi, learned senior counsel, argued that on a cursory look at the persons who constitute the DTAB under Section 5, it is an extremely high ranking body which is the technical expert set up by the statute and, therefore, the High Court judgment is right in stating that in all cases arising under Section 26A prior consultation with the DTAB is a must. He argued, in the alternative, that on a purposive and harmonious construction of the Drugs Act as a whole, a middle approach could be that the Central Government may, in emergent situations, not consult the DTAB, but in all other situations should give reasons why the DTAB was not consulted, otherwise the exercise under Section 26A would be found to be constitutionally infirm. According to the learned senior counsel, hearing is mandatory under the said Section and the High Court's reading in the requirement of hearing into the said Section was absolutely correct. He also referred us to judgments dealing with not only how hearing must be added when it is absent, but to a judgment of this Court which stated that conditional legislation, of which Section 26A is a clear instance, would also require hearing the affected parties.
13. In answer to these submissions, the learned Additional Solicitor General, in rejoinder, went through the 1982 amendment, which introduced Section 26A, and stated that Sections 29 and 35 thereof make it clear that amendments were made in certain Sections with reference to the DTAB under Section 5 and that, therefore, the omission of any reference to the DTAB in Section 26A is deliberate. She also went on to state that Rule 66 of the Drugs Rules, which deals with cancellation of individual licenses and which requires compliance with natural justice, should be contrasted with Section 26A of the Drugs Act which, according to her, is a legislative power as opposed to an administrative power.
14. Having heard learned counsel for the parties, it is first important to set out some of the provisions of the Drugs Act.
 - "5. The Drugs Technical Advisory Board.— (1) The Central Government shall, as soon as may be, constitute a Board (to be called the Drugs Technical Advisory Board) to advise the Central Government and the State Governments on technical matters arising out of the administration of this Act and to carry out the other functions assigned to it by this Act.
 - (2) The Board shall consist of the following members, namely:—
 - (i) the Director General of Health Services, ex officio, who shall be Chairman;
 - (ii) the Drugs Controller, India, ex officio;

- (iii) the Director of the Central Drugs Laboratory, Calcutta, *ex officio*;
 - (iv) the Director of the Central Research Institute, Kasauli, *ex officio*;
 - (v) the Director of the Indian Veterinary Research Institute, Izatnagar, *ex officio*;
 - (vi) the President of the Medical Council of India, *ex officio*;
 - (vii) the President of the Pharmacy Council of India, *ex officio*;
 - (viii) the Director of the Central Drug Research Institute, Lucknow, *ex officio*;
 - (ix) two persons to be nominated by the Central Government from among persons who are in charge of drugs control in the States;
 - (x) one person, to be elected by the Executive Committee of the Pharmacy Council of India, from among teachers in pharmacy or pharmaceutical chemistry or pharmacology on the staff of an Indian university or a college affiliated thereto;
 - (xi) one person, to be elected by the Executive Committee of the Medical Council of India, from among teachers in medicine or therapeutics on the staff of an Indian university or a college affiliated thereto;
 - (xii) one person to be nominated by the Central Government from the pharmaceutical industry;
 - (xiii) one pharmacologist to be elected by the Governing Body of the Indian Council of Medical Research;
 - (xiv) one person to be elected by the Central Council of the Indian Medical Association;
 - (xv) one person to be elected by the Council of the Indian Pharmaceutical Association;
 - (xvi) two persons holding the appointment of Government Analyst under this Act, to be nominated by the Central Government.
- (3) The nominated and elected members of the Board shall hold office for three years, but shall be eligible for re-nomination and re-election: Provided that the person nominated or elected, as the case may be, under clause (ix) or clause (x) or clause (xi) or clause (xvi) of subsection (2) shall hold office for so long as he holds the appointment of the office by virtue of which he was nominated or elected to the Board.
- (4) The Board may, subject to the previous approval of the Central Government, make by-laws fixing a quorum and regulating its own procedure and the conduct of all business to be transacted by it. (5) The Board may constitute sub-committees and may appoint to such sub-committees for such periods, not exceeding three years, as it may decide, or temporarily for the consideration of particular matters, persons who are not members of the Board.
- (6) The functions of the Board may be exercised notwithstanding any vacancy therein.
- (7) The Central Government shall appoint a person to be Secretary of the Board and shall

provide the Board with such clerical and other staff as the Central Government considers necessary.

6. The Central Drugs Laboratory.— (1) The Central Government shall, as soon as may be, establish a Central Drugs Laboratory under the control of a Director to be appointed by the Central Government, to carry out the functions entrusted to it by this Act or any rules made under this Chapter: Provided that, if the Central Government so prescribes, the functions of the Central Drugs Laboratory in respect of any drug or class of drugs or cosmetic or class of cosmetics shall be carried out at the Central Research Institute, Kasauli, or at any other prescribed Laboratory and the functions of the Director of the Central Drugs Laboratory in respect of such drug or class of drugs or such cosmetic or class of cosmetics shall be exercised by the Director of that Institute or of that other Laboratory, as the case may be.
- (2) the Central Government may, after consultation with the Board, make rules prescribing—
- (a) the functions of the Central Drugs Laboratory; *****
 - (d) the procedure for the submission of the said Laboratory under Chapter IV or Chapter IVA of samples of drugs or cosmetics for analysis or test, the forms of Laboratory's reports thereon and the fees payable in respect of such reports;
 - (e) such other matters as may be necessary or expedient to enable the said Laboratory to carry out its functions;
 - (f) the matters necessary to be prescribed for the purposes of the proviso to subsection (1).
7. The Drugs Consultative Committee.— (1) The Central Government may constitute an advisory committee to be called “the Drugs Consultative Committee” to advise the Central Government, the State Governments and the Drugs Technical Advisory Board on any matter tending to secure uniformity throughout India in the administration of this Act.
- (2) The Drugs Consultative Committee shall consist of two representatives of the Central Government to be nominated by that Government and one representative of each State Government to be nominated by the State Government concerned. (3) The Drugs Consultative Committee shall meet when required to do so by the Central Government and shall have power to regulate its own procedure. 7A. Sections 5 and 7 not to apply to Ayurvedic, Siddha or Unani drugs.— Nothing contained in sections 5 and 7 shall apply to Ayurvedic, Siddha or Unani drugs.
8. Standards of quality.— (1) For the purposes of this Chapter, the expression “standard quality” means—
- (a) in relation to a drug, that the drug complies with the standard set out in the Second Schedule, and
 - (b) in relation to a cosmetic, that the cosmetic complies with such standard as may be prescribed.

- (2) The Central Government, after consultation with the Board and after giving by notification in the Official Gazette not less than three months' notice of its intention so to do, may by a like notification add to or otherwise amend the Second Schedule, for the purposes of this Chapter, and thereupon the Second Schedule shall be deemed to be amended accordingly.
10. Prohibition of import of certain drugs or cosmetics.— From such date as may be fixed by the Central Government by notification in the Official Gazette in this behalf, no person shall import—
- (a) any drug or cosmetic which is not of standard quality;
 - (b) any misbranded drug or misbranded or spurious cosmetic;
 - (bb) any adulterated or spurious drug;
 - (c) any drug or cosmetic for the import of which a licence is prescribed, otherwise than under, and in accordance with, such licence;
 - (d) any patent or proprietary medicine, unless there is displayed in the prescribed manner on the label or container thereof the true formula or list of active ingredients contained in it together with the quantities thereof;
 - (e) any drug which by means of any statement, design or device accompanying it or by any other means, purports or claims to cure or mitigate any such disease or ailment, or to have any such other effect, as may be prescribed;
 - (ee) any cosmetic containing any ingredient which may render it unsafe or harmful for use under the directions indicated or recommended;
 - (f) any drug or cosmetic the import of which is prohibited by rule made under this Chapter: Provided that nothing in this section shall apply to the import, subject to prescribed conditions, of small quantities of any drug for the purpose of examination, test or analysis or for personal use: Provided further that the Central Government may, after consultation with the Board, by notification in the Official Gazette, permit, subject to any conditions specified in the notification, the import of any drug or class of drugs not being of standard quality.
12. Power of Central Government to make rules. — (1) The Central Government may, after consultation with or on the recommendation of the Board and after previous publication by notification in the Official Gazette, make rules for the purpose of giving effect to the provisions of this Chapter: Provided that consultation with the Board may be dispensed with if the Central Government is of opinion that circumstances have arisen which render it necessary to make rules without such consultation, but in such a case the Board shall be consulted within six months of the making of the rules and the Central Government shall take into consideration any suggestions which the Board may make in relation to the amendment of the said rules. (2) xxx xxx xxx

16. Standards of quality.— (1) For the purposes of this Chapter, the expression “standard quality” means—
- (a) in relation to a drug, that the drug complies with the standard set out in the Second Schedule, and
 - (b) in relation to a cosmetic, that the cosmetic complies with such standard as may be prescribed. (2) The Central Government, after consultation with the Board and after giving by notification in the Official Gazette not less than three months’ notice of its intention so to do, may by a like notification add to or otherwise amend the Second Schedule for the purposes of this Chapter, and thereupon the Second Schedule shall be deemed to be amended accordingly.
18. Prohibition of manufacture and sale of certain drugs and cosmetics.— From such date as may be fixed by the State Government by notification in the Official Gazette in this behalf, no person shall himself or by any other person on his behalf—
- (a) manufacture for sale or for distribution, or sell, or stock or exhibit or offer for sale, or distribute—
 - (i) any drug which is not of a standard quality, or is misbranded, adulterated or spurious;
 - (ii) any cosmetic which is not of a standard quality or is misbranded, adulterated or spurious;
 - (iii) any patent or proprietary medicine, unless there is displayed in the prescribed manner on the label or container thereof the true formula or list of active ingredients contained in it together with the quantities thereof;
 - (iv) any drug which by means of any statement, design or device accompanying it or by any other means, purports or claims to prevent, cure or mitigate any such disease or ailment, or to have any such other effect as may be prescribed;
 - (v) any cosmetic containing any ingredient which may render it unsafe or harmful for use under the directions indicated or recommended; and
 - (vi) any drug or cosmetic in contravention of any of the provisions of this Chapter or any rule made thereunder;
 - (b) sell, or stock or exhibit or offer for sale, or distribute any drug or cosmetic which has been imported or manufactured in contravention of any of the provisions of this Act or any rule made thereunder;
 - (c) manufacture for sale or for distribution, or sell, or stock or exhibit or offer for sale, or distribute any drug or cosmetic, except under, and in accordance with the conditions of, a licence issued for such purpose under this Chapter:

Provided that nothing in this section shall apply to the manufacture, subject to prescribed conditions,

of small quantities of any drug for the purpose of examination, test or analysis:

Provided further that the Central Government may, after consultation with the Board, by notification in the Official Gazette, permit, subject to any conditions specified in the notification, the manufacture for sale, or for distribution, sale, stocking or exhibiting or offering for sale or distribution of any drug or class of drugs not being of standard quality.

26A. Powers of Central Government to prohibit manufacture, etc., of drug and cosmetic in public interest.— Without prejudice to any other provision contained in this Chapter, if the Central Government is satisfied, that the use of any drug or cosmetic is likely to involve any risk to human beings or animals or that any drug does not have the therapeutic value claimed or purported to be claimed for it or contains ingredients and in such quantity for which there is no therapeutic justification and that in the public interest it is necessary or expedient so to do, then, that Government may, by notification in the Official Gazette, regulate, restrict or prohibit the manufacture, sale or distribution of such drug or cosmetic.

33. Power of Central Government to make rules. — (1) The Central Government may after consultation with, or on the recommendation of, the Board and after previous publication by notification in the Official Gazette, make rules for the purpose of giving effect to the provisions of this Chapter: Provided that consultation with the Board may be dispensed with if the Central Government is of opinion that circumstances have arisen which render it necessary to make rules without such consultation, but in such a case the Board shall be consulted within six months of the making of the rules and the Central Government shall take into consideration any suggestions which the Board may make in relation to the amendment of the said rules. (2) Without prejudice to the generality of the foregoing power, such rules may—

- (a) provide for the establishment of laboratories for testing and analysing drugs or cosmetics;
- (b) prescribe the qualifications and duties of Government Analysts and the qualifications of Inspectors;
- (c) prescribe the methods of test or analysis to be employed in determining whether a drug or cosmetic is of standard quality;
- (d) prescribe, in respect of biological and organometallic compounds, the units or methods of standardisation;
- (dd) prescribe under clause (d) of [section 17A](#) the colour or colours which a drug may bear or contain for purposes of colouring;
- (dda) prescribe under clause (d) of [section 17E](#) the colour or colours which a cosmetic may bear or contain for the purpose of colouring;
- (e) prescribe the forms of licences for the manufacture for sale or for distribution, for the sale and for the distribution of drugs or any specified drug or class of

drugs or of cosmetics or any specified cosmetic or class of cosmetics, the form of application for such licences, the conditions subject to which such licences may be issued, the authority empowered to issue the same, the qualifications of such authority and the fees payable therefor; and provide for the cancellation or suspension of such licences in any case where any provision of this Chapter or the rules made thereunder is contravened or any of the conditions subject to which they are issued is not complied with; (ee) prescribe the records, registers or other documents to be kept and maintained under [section 18B](#);

- (eea) prescribe the fees for the inspection (for the purposes of grant or renewal of licences) of premises, wherein any drug or cosmetic is being or is proposed to be manufactured;
- (eeb) prescribe the manner in which copies are to be certified under sub-section (2A) of [section 22](#);
- (f) specify the diseases or ailments which a drug may not purport or claim to prevent, cure or mitigate and such other effects which a drug may not purport or claim to have;
- (g) prescribe the conditions subject to which small quantities of drugs may be manufactured for the purpose of examination, test or analysis;
- (h) require the date of manufacture and the date of expiry of potency to be clearly or truly stated on the label or container of any specified drug or class of drugs, and prohibit the sale, stocking or exhibition for sale, or distribution of the said drug or class of drugs after the expiry of a specified period from the date of manufacture or after the expiry of the date of potency;
- (i) prescribe the conditions to be observed in the packing in bottles, packages, and other containers of drugs or cosmetics, including the use of packing material which comes into direct contact with the drugs and prohibit the sale, stocking or exhibition for sale, or distribution of drugs or cosmetics packed in contravention of such conditions;
- (j) regulate the mode of labelling packed drugs or cosmetics, and prescribe the matters which shall or shall not be included in such labels;
- (k) prescribe the maximum proportion of any poisonous substance which may be added or contained in any drug, prohibit the manufacture, sale or stocking or exhibition for sale, or distribution of any drug in which that proportion is exceeded, and specify substances which shall be deemed to be poisonous for the purposes of this Chapter and the rules made thereunder;
- (l) require that the accepted scientific name of any specified drug shall be displayed in the prescribed manner on the label or wrapper of any patent or proprietary medicine containing such drug;

[****]

- (n) prescribe the powers and duties of Inspectors and the qualifications of the authority to which such Inspectors shall be subordinate and specify the drugs or classes of drugs or cosmetics or classes of cosmetics in relation to which and the conditions, limitations or restrictions subject to which, such powers and duties may be exercised or performed;
- (o) prescribe the forms of report to be given by Government Analysts, and the manner of application for test or analysis under [section 26](#) and the fees payable therefor;
- (p) specify the offences against this Chapter or any rule made thereunder in relation to which an order of confiscation may be made under [section 31](#);
- (q) provide for the exemption, conditionally or otherwise, from all or any of the provisions of this Chapter or the rules made thereunder, of any specified drug or class of drugs or cosmetic or class of cosmetics; and
- (r) sum which may be specified by the Central Government under [section 32-B](#).

33EED. Power of Central Government to prohibit manufacture, etc., of Ayurvedic, Siddha or Unani drugs in public interest.— Without prejudice to any other provision contained in this Chapter, if the Central Government is satisfied on the basis of any evidence or other material available before it that the use of any Ayurvedic, Siddha or Unani drug is likely to involve any risk to human beings or animals or that any such drug does not have the therapeutic value claimed or purported to be claimed for it and that in the public interest it is necessary or expedient so to do then, that Government may, by notification in the Official Gazette, prohibit the manufacture, sale or distribution of such drug.

33N. Power of Central Government to make rules.— (1) The Central Government may, after consultation with, or on the recommendation of, the Board and after previous publication by notification in the Official Gazette, make rules for the purpose of giving effect to the provisions of this Chapter: Provided that consultation with the Board may be dispensed with if the Central Government is of opinion that circumstances have arisen which render it necessary to make rules without such consultation, but in such a case, the Board shall be consulted within six months of the making of the rules and the Central Government shall take into consideration any suggestions which the Board may make in relation to the amendment of the said rules. (2) Without prejudice to the generality of the foregoing power, such rules may—

- (a) provide for the establishment of laboratories for testing and analysing Ayurvedic, Siddha or Unani drugs;
- (b) prescribe the qualification and duties of Government Analysts and the qualifications of Inspectors;
- (c) prescribe the methods of test or analysis to be employed in determining whether any

Ayurvedic, Siddha or Unani drug is labelled with the true list of the ingredients which it is purported to contain;

- (d) specify any substance as a poisonous substance;
- (e) prescribe the forms of licences for the manufacture for sale of Ayurvedic, Siddha or Unani drugs, and for sale of processed Ayurvedic, Siddha or Unani drugs, the form of application for such licences, the conditions subject to which such licences may be issued, the authority empowered to issue the same and the fees payable therefor; and provide for the cancellation or suspension of such licences in any case where any provision of this Chapter or rules made thereunder is contravened or any of the conditions subject to which they are issued is not complied with;
- (f) prescribe the conditions to be observed in the packing of Ayurvedic, Siddha and Unani drugs including the use of packing material which comes into direct contact with the drugs, regulate the mode of labelling packed drugs and prescribe the matters which shall or shall not be included in such labels;
- (g) prescribe the conditions subject to which small quantities of Ayurvedic, Siddha or Unani drugs may be manufactured for the purpose of examination, test or analysis;
- (gg) prescribe under clause (d) of section 33EE the colour or colours which an Ayurvedic, Siddha or Unani drug may bear or contain for purposes of colouring;
- (gga) prescribe the standards for Ayurvedic, Siddha or Unani drugs under section 33EEB;
- (ggb) prescribe the records, registers or other documents to be kept and maintained under section 33 KB; and
- (h) any other matter which is to be or may be prescribed under this Chapter.”

15. Having heard learned counsel for the parties, it is clear that Section 26A has been introduced by an amendment in 1982. A bare reading of this provision would show, firstly, that it is without prejudice to any other provision contained in this Chapter (meaning thereby Chapter IV). This expression only means that apart from the Central Government's other powers contained in Chapter IV, Section 26A is an additional power which must be governed by its own terms. Under Section 26A, the Central Government must be “satisfied” that any drug or cosmetic is likely to involve (i) any risk to human beings or families; or (ii) that any drug does not have the therapeutic value claimed or purported to be claimed for it; or (iii) contains ingredients in such quantity for which there is no therapeutic justification. Obviously, the Central Government has to apply its mind to any or all of these three factors which has to be based upon its “satisfaction” as to the existence of any or all of these factors. The power exercised under Section 26A must further be exercised only if it is found necessary or expedient to do so in public interest. When the power is so exercised, it may regulate, restrict or prohibit manufacture, sale or distribution

of any drug or cosmetic. 16. Undoubtedly, Section 26A has to be read with the rest of the Drugs Act. So read, it is clear that unlike Section 6(2), Section 8(2), proviso to Section 10, proviso to Section 12(1), Section 16(2), proviso to Section 18(2), Section 33 and Section 33N, there is no explicit requirement to consult the DTAB set up under Section 5 of the Drugs Act. The question is did the Parliament do so deliberately or is it something that the Court should read into the provision?

17. As has been stated hereinabove, Section 26A was brought in by an amendment in 1982. The amendment specifically made changes in Sections 33 and 33N in which it added the words “on the recommendation of the Board”. From this, it is clear that Parliament in the very Amendment Act which introduced Section 26A made certain changes which involved the DTAB under Section 5 of the said Act. It is clear that the additional power that is given to the Central Government under Section 26A does not refer to and, therefore, mandate any previous consultation with the DTAB. On the contrary, the Central Government may be “satisfied” on any relevant material that a drug is likely to involve any risk to human beings etc. as a result of which it is necessary in public interest to regulate, restrict or prohibit manufacture, sale or distribution thereof. So long as the Central Government’s satisfaction can be said to be based on relevant material, it is not possible to say that not having consulted the DTAB, the power exercised under the said Section would be non est. Take the case of an FDC that is banned in 50 countries of the world owing to the fact that the said FDC involved significant risk to human beings. Assuming that the Central Government is satisfied based on this fact alone, which in turn is based on expert committee reports in various nations which pointed out the deleterious effects of the said drug, can it be said that without consulting the DTAB set up under Section 5, the exercise of the power under Section 26A to prohibit the manufacture or sale or distribution of a drug that is banned in 50 countries would be bad only because the DTAB has not been consulted? The obvious answer is no inasmuch as the Central Government’s satisfaction is based upon relevant material, namely, the fact that 50 nations have banned the aforesaid drug, which in turn is based on expert committee reports taken in each of those nations. Take another example. Suppose the Central Government were to ban an FDC on the ground that, in the recent past, it has been apprised of the fact that the FDCs taken over a short period of time would lead to loss of life, which has come to the notice of the Central Government through reports from various district authorities, in let us say, a majority of districts in which the said FDC has been consumed. Could not the Central Government then base its ban order on material collected from district authorities which state that this particular drug leads to human mortality and ought, therefore, to be prohibited? The obvious answer again is yes for the reason that the Central Government has been satisfied on relevant material that it is necessary in public interest to ban such drug. Examples of this nature can be multiplied to show that the width of the power granted under Section 26A cannot be cut down by artificially cutting down the language of Section 26A.

18. We were referred to a judgment of this Court in *Systopic Laboratories* (supra) at 169. Paragraph

19 of the said judgment reads as follows:-

“19. Having considered the submissions made by the learned counsel for the petitioners and the learned Additional Solicitor General in this regard, we must express our inability to make an assessment about the relative merits of the various studies and reports which have been placed before us. Such an evaluation is required to be done by the Central Government while exercising its powers under Section 26-A of the Act on the basis of expert advice and the Act makes provision for obtaining such advice through the Board and the DCC.”

19. It is clear that a stray sentence in a judgment without a focused argument cannot be considered as the ratio of such a judgment. Also, on a careful reading of the second sentence in paragraph 19, it is clear that all that is stated by this Court is that, while exercising its power under Section 26A of the Drugs Act, the basis of the Central Government’s decision must be “expert advice”. The sentence then goes on to add that the Drugs Act makes provision for obtaining such advice through the Board and the DCC. According to us, there was no focused argument on whether such advice is or is not mandatory before powers under Section 26A of the Drugs Act can be exercised, and merely reading a stray sentence in this judgment does not lead to such a conclusion. Equally, the single Judge’s reliance upon a Division Bench judgment contained in *E. Merck (supra)*, where, in holding Section 26A to be constitutional, the Court stated:

“Before the Government records its satisfaction to prohibit the manufacture, sale, distribution etc. of a particular drug, opinion of the DTAB and/or Drugs Consultative Committee is obtained.” This is an equally stray sentence and what has been stated with respect to Systopic Laboratories (*supra*), applies equally to this sentence.

20. We have now to consider certain other arguments made on behalf of the respondents. One argument was that Section 5 is in two parts and that the first part necessarily applies to all technical matters that arise out of the administration of the Drugs Act, and that, therefore, the Central Government is bound to take the advice of the DTAB in all such matters. We must first advert to the fact that the DTAB is only an advisory body. No doubt, it would be desirable for the Central Government to take its advice on technical matters arising out of the administration of the Drugs Act, but this does not lead to the conclusion that if such advice is not taken power under Section 26A cannot be exercised. Indeed, the Central

Government’s satisfaction may be based on a number of factors, one of which may be advice tendered to it by the DTAB under Section 5. There is no warrant to read Section 26A to constrict the wide powers granted to the Central Government by a so-called harmonious construction of the statute. Another argument made is that Section 5 makes it clear that the DTAB alone can constitute sub-committees which may have persons who are not members of the Board on them. We are afraid that this again does not lead us very far. It is clear that the reason for Section 5(5) is completely different. Sub-committees may be appointed for such periods not exceeding three years or temporarily for the consideration of particular matters. Such sub-committees may be set up in the wisdom of the DTAB for short periods of time or

temporarily to consider certain matters and make reports which the DTAB may then utilize. This is a power of the DTAB which can be exercised when the DTAB deems it desirable. From this power, it cannot be inferred, as a matter of logic, that since [Section 5\(5\)](#) permits persons who are not members of the board to sit on sub-committees, the Central Government may not, under [Section 26A](#), refer to any persons other than those who are board members. This argument, therefore, is also rejected.

21. Yet another argument has been made that since [Section 10A](#) and [26A](#) were brought in together by an [Amendment Act](#) in 1982, it must, therefore, somehow be assumed that the [Amendment Act](#) necessarily included a mandatory consultation with the DTAB set up under [Section 5](#). We have already pointed out how the very amendment Act of 1982 also amended [Sections 33](#) and [33N](#) by referring to the DTAB and that, therefore, it is obvious that the omission of any reference to the DTAB under [Sections 10A](#) and [26A](#) cannot but be said to be deliberate. This argument also need not detain us further.
22. A negative argument was made stating that [Section 7A](#) of the Drugs Act makes it clear that [Section 5](#) will not apply to Ayurvedic, Siddha or Unani drugs and that, therefore, it will apply to all other drugs. The reason for [Section 7A](#) is again something very different from what has been argued. It must first be pointed out that under Chapter IVA, which is a separate Chapter introduced by Act 13 of 1964, Ayurvedic, Siddha and Unani drugs are completely separately dealt with. Indeed, [Section 33A](#), which must be read with [Section 7A](#), expressly provides that save as provided in this [Drugs Act](#), nothing contained in this Chapter, i.e. Chapter IV, shall apply to Ayurvedic, Siddha or Unani drugs. Chapter IVA consists of a separate and distinct drill to be followed in the case of Ayurvedic, Siddha and Unani drugs. Under [Section 33C](#), there is a separate technical advisory board for Ayurvedic and Unani drugs and a separate consultative committee for Ayurvedic, Siddha and Unani drugs (see [Section 33D](#)). When [Section 7A](#) says that nothing in [section 5](#) shall apply to Ayurvedic, Siddha or Unani drugs, all that it affirms is that the DTAB set up under [Section 5](#) will apply to all drugs except Ayurvedic, Siddha or Unani medicines. The Latin maxim “expressio unius est exclusio alterius” cannot apply, as has been held in *State of Karnataka v Union of India & Ors.*, (1977) 4 SCC 608 at 662, making it clear that the said maxim should be very carefully applied and when misapplied would turn out to be a “dangerous master” as opposed to a “useful servant”. This has also been held in *Assistant Collector of Central Excise, Calcutta Division v. National Tobacco Co. of India Ltd .*, (1972) 2 SCC 560 at 575 as follows:

“The High Court’s view was based on an application of the rule of construction that where a mode of performing a duty is laid down by law it must be performed in that mode or not at all. This rule flows from the maxim: “Expressio unius est exclusio alterius”. But, as was pointed out by Wills, J., in *Colguoboun v. Brooks* [(1888) 21 QBD 52, 62] this maxim “is often a valuable servant, but a dangerous master....”. The rule is subservient to the basic principle that Courts must endeavour to ascertain the legislative intent and purpose, and then adopt a rule of construction which effectuates rather than one that may defeat these. “ This argument, therefore, also need not detain us.

23. It was also argued that [Section 26A](#) had no non obstante clause to keep [Section 5](#) out of harm's way. On our construction of [Section 26A](#), it is clear that no such non obstante clause was necessary in that the width of the expression "is satisfied" contained in [Section 26A](#) cannot be cut down by reference to [Section 5](#). As has been stated by us hereinabove, the expression "without prejudice" makes it clear that [Section 26A](#) is an additional power given to the Central Government which must be exercised on its own terms.
24. An argument was made that unless the provisions of [Section 5](#) requiring consultation with the DTAB are read into [Section 26A](#), the said Section would be arbitrary. In our opinion, there are sufficient indicators in the Section to eschew any ground of arbitrariness. The power can only be exercised based on satisfaction of material that is relevant to form an opinion that the drug in question falls within any of the three categories outlined by the Section and that, further, it is necessary or expedient to either regulate, restrict or prohibit manufacture, sale or distribution of the said drug in public interest. Indeed, this is made explicit in Section 33 EED of the Drugs Act, wherein a similar power is given to the Central Government qua Ayurvedic, Siddha or Unani drugs, where the Section states:
- "... the Central Government is satisfied on the basis of any evidence or other material available before it that ..."
25. If the power under [Section 26A](#) is exercised on the basis of irrelevant material or on the basis of no material, the satisfaction itself that is contemplated by [Section 26A](#) would not be there and the exercise of the power would be struck down on this ground. Further, it is argued that the provision may be read down to make it constitutionally valid, but in so doing, words cannot be added as a matter of constitutional doctrine.
26. [In Cellular Operators Association of India and others v. Telecom Regulatory Authority of India and others](#), (2016) 7 SCC 703 at 740-741, this Court held as under:

"50. But it was said that the aforesaid Regulation should be read down to mean that it would apply only when the fault is that of the service provider. We are afraid that such a course is not open to us in law, for it is well settled that the doctrine of reading down would apply only when general words used in a statute or regulation can be confined in a particular manner so as not to infringe a constitutional right. This was best exemplified in one of the earliest judgments dealing with the doctrine of reading down, namely, the judgment of the Federal Court in [Hindu Women's Rights to Property Act, 1937](#), *In re* [[Hindu Women's Rights to Property Act, 1937](#), *In re*, AIR 1941 FC 72]. In that judgment, the word "property" in [Section 3](#) of the [Hindu Women's Rights to Property Act](#) was read down so as not to include agricultural land, which would be outside the Central Legislature's powers under the Government of India Act, 1935. This is done because it is presumed that the legislature did not intend to transgress constitutional limitations. While so reading down the word "property", the Federal Court held:

"... If the restriction of the general words to purposes within the power of the legislature

would be to leave an Act with nothing or next to nothing in it, or an Act different in kind, and not merely in degree, from an Act in which the general words were given the wider meaning, then it is plain that the Act as a whole must be held invalid, because in such circumstances it is impossible to assert with any confidence that the legislature intended the general words which it has used to be construed only in the narrower sense: *Owners of SS Kalibia v.*

Wilson [(1910) 11 CLR 689 (Aust)], *Vacuum Oil Co. Pty. Ltd. v. Queensland* [(1934) 51 CLR 677 (Aust)], *R. v.*

Commonwealth Court of Conciliation and Arbitration, ex p Whybrow & Co. [(1910) 11 CLR 1 (Aust)] and *British Imperial Oil Co. Ltd. v. Federal Commr. of Taxation* [(1925) 35 CLR 422 (Aust)].”

51. This judgment was followed by a Constitution Bench of this Court in *DTC v. Mazdoor Congress* [1991 Supp (1) SCC 600 : 1991 SCC (L&S) 1213]. In that case, a question arose as to whether a particular regulation which conferred power on an authority to terminate the services of a permanent and confirmed employee by issuing a notice terminating his services, or by making payment in lieu of such notice without assigning any reasons and without any opportunity of hearing to the employee, could be said to be violative of the appellants’ fundamental rights. Four of the learned Judges who heard the case, the Chief Justice alone dissenting on this aspect, decided that the regulation cannot be read down, and must, therefore, be held to be unconstitutional. In the lead judgment on this aspect by Sawant, J., this Court stated: (SCC pp. 728-29, para 255) “255. It is thus clear that the doctrine of reading down or of recasting the statute can be applied in limited situations. It is essentially used, firstly, for saving a statute from being struck down on account of its unconstitutionality. It is an extension of the principle that when two interpretations are possible — one rendering it constitutional and the other making it unconstitutional, the former should be preferred. The unconstitutionality may spring from either the incompetence of the legislature to enact the statute or from its violation of any of the provisions of the Constitution. The second situation which summons its aid is where the provisions of the statute are vague and ambiguous and it is possible to gather the intentions of the legislature from the object of the statute, the context in which the provision occurs and the purpose for which it is made. However, when the provision is cast in a definite and unambiguous language and its intention is clear, it is not permissible either to mend or bend it even if such recasting is in accord with good reason and conscience. In such circumstances, it is not possible for the court to remake the statute. Its only duty is to strike it down and leave it to the legislature if it so desires, to amend it. What is further, if the remaking of the statute by the courts is to lead to its distortion that course is to be scrupulously avoided.

One of the situations further where the doctrine can never be called into play is where the statute requires extensive additions and deletions. Not only it is no part of the court’s duty to undertake such exercise, but it is beyond its jurisdiction to do so.” (emphasis supplied)

52. Applying the aforesaid test to the impugned Regulation, it is clear that the language of the Regulation is definite and unambiguous — every service provider has to credit the account of the calling consumer by one rupee for every single call drop which occurs within its network. The Explanatory Memorandum to the aforesaid Regulation further makes it clear, in Para 19 thereof, that the Authority has come to the conclusion that call drops are instances of deficiency in service delivery on the part of the service provider. It is thus unambiguously clear that the impugned Regulation is based on the fact that the service provider is alone at fault and must pay for that fault. In these circumstances, to read a proviso into the Regulation that it will not apply to consumers who are at fault themselves is not to restrict general words to a particular meaning, but to add something to the provision which does not exist, which would be nothing short of the court itself legislating. For this reason, it is not possible to accept the learned Attorney General’s contention that the impugned Regulation be read down in the manner suggested by him.”
27. Also, as a matter of statutory interpretation, words can only be added if the literal interpretation of the Section leads to an absurd result. As has been stated by us, the construction of Section 26A on a literal reading thereof does not lead

All India Drug Action Network vs Union of India W.P (C) No 8555/2018

* IN THE HIGH COURT OF DELHI AT NEW DELHI

+ W.P.(C) 6084/2018, C.M. APPL.23517/2018

BGP PRODUCTS OPERATIONS GMBH AND ANR.

versus

UNION OF INDIA AND ORS

..... Petitioners

..... Respondents

+ W.P.(C) 8555/2018, C.M. APPL.32864/2018 & 34112/2018 ALL INDIA DRUG ACTION NETWORK

versus

UNION OF INDIA AND ANR.

..... Petitioner

..... Respondents

+ W.P.(C) 8666/2018, C.M. APPL.33281/2018 NEON LABORATORIES LTD.

versus

UNION OF INDIA AND ORS.

..... Petitioner

..... Respondents

+ W.P.(C) 9601/2018, C.M. APPL.37387/2018 & 37388/2018 CIRON DRUGS AND PHARMACEUTICALS PVT. LTD. AND ANR.

UNION OF INDIA AND ORS.

..... Petitioner

versus

..... Respondents

Through: Ms. Olivia Bang and Ms. Harini Raghupathy, Advocates, in Item Nos. 4 to 7.
Sh. Ravikesh Kumar Sinha, Advocate, for petitioner, in Item No.4.
Mr. Ashish Prasad, Ms. Mukta Dutta, Mr. Rohan Roy, Advocates in Item No.4
Sh. Varun Singh, Sh. Gaurav Nair and Ms. Pranati Bhatnagar, Advocates, for petitioner, in Item No.7.

CORAM:

HON'BLE MR. JUSTICE S. RAVINDRA BHAT

HON'BLE MR. JUSTICE A.K. CHAWLA

O R D E R

% 30.11.2018

Judgment in these cases was reserved on 25.10.2018. In the meanwhile, this court vide interim orders dated 28.09.2018 and 25.10.2018 suspended the impugned notifications. The judgment has not yet been delivered. In these circumstances, the interim orders are directed to be continued up to 15th December 2018.

S. RAVINDRA BHAT, J

A.K. CHAWLA, J

NOVEMBER 30, 2018

pkb

The Human Rights Law Network (HRLN) is a collective of lawyers and social activists dedicated to using the legal system to advance human rights in India and to ensure access to justice for victims of human rights violations. A not-for-profit, non-governmental, human rights organisation, HRLN recognizes rights broadly to include civil and political as well as economic, social, and cultural rights. Recognising law as an area of struggle, HRLN views the legal system as a limited but crucial weapon for realising human rights.

We believe that large scale struggles against human rights violations have to be waged by social and political movements and that the legal system can play a significant supportive role in these.

Starting in 1989 as an ad hoc group of lawyers and social activists, HRLN has since evolved into a human rights organisation with dedicated activists, lawyers, and social workers in all Indian states. In addition to pro-bono legal services and public interest litigation, HRLN engages in legal advocacy both inside and outside of the courts including conducting legal workshops and investigations, publishing “Know Your Rights” material, and participating in campaigns. In collaboration with social movements and human rights and development organisations, HRLN works on behalf of the rights of women, prisoners, Dalits, workers, children, farmers, indigenous people, refugees, HIV positive people, people with disabilities, religious minorities, sexual minorities, and the homeless among others.

