# CLAIMING DIGNITY:
## REPRODUCTIVE RIGHTS & THE LAW

HRLN
Human Rights Law Network

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## Human Rights Law Network's 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, and efficient and affordable, and works for the underpriviledged.
- Raise the level of pro-bono legal experience for the poor to make the work uniformly competent as well as compassionate.
- Professionally train a new generation of public interest lawyers and paralegals who are comfortable in the world of law as well as in social movements and who lean from such movements to refine legal concepts and strategies.

**CLAIMING DIGNITY: REPRODUCTIVE RIGHTS & THE LAW**

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# Contents

# Introduction

Today in India, one woman will die from a pregnancy related cause every 10 minutes.[1]

Public health officials in India routinely deny women active control over their reproductive choices. In the first half of 2012, scandals involving mass hysterectomies and unethical and illegal sterilization camps made headlines. HIV/AIDS positive, Dalit, and Below the Poverty Line (BPL) women have been evicted from hospitals while in labor. Child marriage continues to limit opportunities for millions of Indian women and four state governments have completely banned sexual health education for adolescents. Despite increased awareness, government schemes, and international pressure, women in India continue to face immense obstacles in accessing or exercising their reproductive rights.

Since HRLN published the first edition of *Claiming Dignity* in 2009, lawyers throughout India have filed petitions on myriad reproductive issues including maternal mortality, denial of reproductive health care, discrimination against HIV positive pregnant women, coercive population control policies, inhumane sterilization camps, unsafe abortion services, unethical surrogacy, and sex selective abortion. The work of diligent advocates throughout India has spurred High Courts in many states to issue increasingly progressive judgments in reproductive rights cases. In this context, momentum is building for reproductive rights litigation; now is the time to investigate, document, litigate, and ensure implementation of Court orders.

This book provides a brief summary of the most important reproductive rights cases and an abridged version of the Court's judgment or orders. HRLN has designed this book to be a practical tool for advocates and activists. The book serves as a resource for drafting reproductive rights petitions, developing human rights trainings, and inspiring activists to drive meaningful legal change.

The introduction defines reproductive rights, outlines the major reproductive rights issues in India, discusses the most relevant domestic constitutional provisions, laws, and schemes, and details international legal obligations. It is important to note that reproductive rights encompass an infinite range of issues and situations. This book examines a sampling of the most pressing reproductive rights issues currently making their way though the Indian legal system.

HRLN hopes that advocates and activists will use this book to expand the scope of reproductive rights and to increase avenues toward justice for women and marginalized communities.

1 *U.N.: India likely to miss MDG on maternal health,* The Hindu, 3 July 2012.

## Reproductive Rights Defined:

This book relies on the definition of reproductive rights issued by the 1994 Cairo International Conference on Population and Development (ICPD). According to the ICPD,

> 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.[2]

Under this conceptualization of reproductive rights, the law can be used as an effective means to end policies that limit individual autonomy, to ensure minimum entitlements, and to combat discrimination.

## Major Reproductive Rights Issues in India

Although men and women have an equal stake in all human rights, reproductive rights issues disproportionately impact women. Reproductive rights become closely linked to women's rights because gender discrimination and inequality set the stage for the majority of reproductive rights violations.

A 2012 poll of G20 countries ranks India as the worst place to be a woman.[3] Staggeringly high maternal mortality and infant mortality rates, limited access to contraceptives, nonexistent sexual health education and information, coercive population control policies, unsafe abortion, rampant child marriage, and compounded discrimination based on caste, religion, disability, and socioeconomic status fuel inequality and perpetuate violations of women's reproductive rights in India. This section provides a very brief introduction to the most crucial reproductive rights issues in India today.

### Maternal Mortality and Morbidity

Maternal mortality measures the number of women aged 15 – 49 who die in maternal-health related causes. More than 100,000 Indian women die every year as a result of

2 Chapter VII, Reproductive Rights and Reproductive Health, International Conference on Population and Development, Cairo, 1994.

3 *Canada best G20 country to be a woman, India worst,* TrustLaw, 13 June 2012.

pregnancy related causes and India represents the highest number of maternal deaths in the world.[4]

A country's Maternal Mortality Ratio (MMR) is the number of maternal deaths for every 100,000 live births. According to Government statistics, India has recently reduced its MMR to 212.[5] This number does not accurately portray the extreme variations across regions and within individual states. Several states in India still report shockingly high MMRs. Assam, in the northeast, has an MMR of 390, Uttar Pradesh, India's largest state, reports an MMR of 359, Rajasthan has an MMR of 318, and Bihar's ratio is 261.[6] These numbers, do not necessarily reflect the reality on the ground, as many states do not have adequate or timely data on maternal mortality. India has pledged to meet its Millennium Development Goal (MDG) to reduce the MMR to 109 by 2015. As of 2012, only three Indian states, Tamil Nadu, Kerala, and Maharashtra, have succeeded.

The vast majority of maternal deaths are wholly preventable. Maternal health experts have determined that three preventable delays result in maternal death: 1. An initial delay in obtaining antenatal health care; 2. A delay in reaching care; and 3. A delay in receiving care at the facility.

Initially, a woman may not have antenatal care where there is a failure to recognize complications, where women's health is not a priority, where women do not have the freedom or opportunity to seek out care, and where healthcare is nonexistent or unavailable. When delivery or an emergency occurs, poor infrastructure, unavailable or costly transportation, and constant referrals prolong medical emergencies that contribute to maternal mortality. Finally, when a woman does reach a medical facility, inadequate staff, facilities, supplies, and hygiene contribute to maternal deaths. In some cases, discrimination based on HIV status, religion, caste, or socioeconomic status results in a complete denial of care and results in maternal mortality.

In India, most women perish in pregnancy related deaths as a result of hemorrhaging, limited access to hygienic institutional delivery, anemia, and malnourishment. According to UNICEF, more than half of all married women in India are anemic, a contributing factor to maternal death and morbidity.[7] Moreover, the 2011 Human Development

4 *Maternal Deaths Halved in 20 Years, but Faster Progress Needed,* UNFPA (United Nations Population Fund) 16 May 2012.

5 Annual Report to the People on Health, Ministry of Health and Family Welfare, Government of India, December 2011.

6 Report of the Working Group on National Rural Health Mission for the Twelfth Five Year Plan (2012-2017), Ministry of Health and Family Welfare, Government of India, para. 1.3.4.

7 *Child Undernutrition in India: A Gender Issue, Speech by UNICEF Country Representative Karin Hulshof as part of a panel of Undernutrition and Gender in India chaired by the Ministry of Women and Child Development,* citing the National Family Health Survey-3 (2005-2006).

Report shows a higher incidence of anemia in marginalized groups including Scheduled Castes and Scheduled Tribes.[8] Anemia is completely preventable and treatable with proper nutrition, life skills education, and medical care.

India's high MMR has gained attention from human rights groups and the United Nations. In 2007, the Committee for the Elimination of all forms of Discrimination Against Women expressed its continued concerns regarding women's health in India generally and maternal mortality specifically.[9]

To combat maternal mortality, the government of India has introduced the National Rural Health Mission (NRHM) and accompanying schemes to strongly promote institutional delivery. At the same time, activists and health workers have implemented new strategies and developed advocacy to spur the government into action on this crucial issue. Litigation comprises a fundamental component of the struggle against maternal mortality in India. As a result of developing jurisprudence, Courts have taken an important lead in ensuring adequate, affordable, and accessible maternal health care for women in India.

## Access to Contraception and Information

To fully exercise their reproductive rights, women must have access to a wide range of contraceptives, information about those options, and the medical care necessary to effectively exercise their choices. Although the Indian Government has pushed contraceptive use as part of a wider population control policy, only 56% of married women ages 15-49 currently employ any form of contraception.[10]

India's official National List of Essential Medicines includes the birth control pill, intrauterine devices, condoms, and hormonal devices.[11] The National Family Welfare Programme, provides condoms and oral contraceptives free of charge. Moreover, under the National Rural Health Mission (NRHM), women should have access to spacing methods (oral contraceptives, condoms, IUDs) and counseling from Accredited Social Health Activists (ASHAs), sub health centers and Primary Health Centers (PHCs). Accordingly, these contraceptives must be widely and inexpensively available to women in India.

8 India Human Development Report 2011, Institute of Manpower Research, Planning Commission, Government of India, October 2011.

9 Concluding Comments on India, Committee on the Elimination of All Forms of Discrimination against Women, 37th Session, CEDAW/C/IND/CO/3, 2 February 2007.

10 *National Family Health Survey (NFHS-3)* 2005-2006, Ministry of Health and Family Welfare, p. 8.

11 National List of Essential Medicines of India, Central Drugs Standard Control Organization, Government of India, 2011.

At 38%, female sterilization is the most common form of contraception for married women age 15-49, while 3% of married women opt for the birth control pill (BCP), 2% use intrauterine devices (IUD), and 5% use condoms.[12] Permanent birth control through female sterilization comprises about 75% of all modern contraceptive use in India. In fact, the three modern spacing methods (BCP, IUD, condoms) only account for 10% of all contraceptives.

Contraceptive use is also low among adolescents and unmarried women. A 2011 report shows that condom use is extremely low among young people who have premarital sex. When engaging in premarital sex, only 7% of young women have ever used a condom and an alarmingly low number of young men, 27%, have ever used a condom.[13]

### Access to safe abortion

Inadequate access to contraception increases the need for abortion. Data shows that 80% of women who obtain abortions in India do not use contraception.[14] Although the 1979 Medical Termination of Pregnancy (MTP) Act legalized abortion up to the 20th week of pregnancy, about 20,000 Indian women die every year as a result of unsafe abortion.[15] Worldwide, unsafe abortion accounts for 13% of all maternal deaths.[16] Although the NRHM mandates PHCs to provide MTPs, fewer than 20% of all PHCs have the capacity to conduct the procedure. [17]

Injury and death from unsafe abortion results when doctors, nurses, or traditional practitioners perform MTPs in an environment that does not meet Indian Public Health Standards. In other cases, issues with patient confidentiality and inadequate access to quality services drive women to obtain clandestine abortions.

Like other reproductive rights issues, unsafe abortions primarily impact poor and marginalized women. The 2008 Annual Survey from the Ministry of Health and Family Welfare found that married wealthy women obtain MTPs from private facilities, whereas "the women admitted to public hospitals with complications from illegal septic abortions are

12 *National Family Health Survey (NFHS-3)* 2005-2006, Ministry of Health and Family Welfare, p. 8.

13 K.G. Santhya, et. Al., *Condom Use Before Marriage and Its Correlates: Evidence from India,* International Perspectives on Sexual and Reproductive Health Vol. 37, No. 4, GuttmacherInstitute, 2011.

14 AnjuMalhotra, et. al, *Realizing Reproductive Choice and Rights: Abortion and Contraception in India,* International Center for Research on Women, 2003, p. 22.

15 Consortium on National Consensus for Medical Abortion in India, 20 November 2008, Introduction, p. XX.

16 *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008,* World Health Organization, 2011.

17 David A. Grimes, et. Al., *Unsafe Abortion: the Preventable Pandemic,* The Lancet, 2006.

largely illiterates and from poorer segments of the population."[18]

## Coercive Population Policy

Although the total fertility rate (TFR), or the average number of children born to a woman who survives to the end of her reproductive cycle, has declined in India, the government, NGOs, and policy makers have remained adamant about showing India's population growth through controlling fertility.

Today, female sterilization remains the most widely used form of contraception in India. The prevalence of female sterilization is highest among women from "backward classes." After a Supreme Court ruling in *Ramakant Rai vs Union of India*, the Government of India developed extensive guidelines for sterilization in 2006.[19] Despite the guidelines and an official push away from establishing sterilization minimums, state governments and public health workers continue to promote sterilization to the exclusion of alternative methods of contraception. In disregard of accepted notions of free consent, both field workers who recruit women for sterilization and women who agree to be sterilized receive cash incentive payments.

Female sterilization is a permanent and radical form of birth control that involves a surgery to close or block the fallopian tubes. A doctor may cut and tie, clip, or clamp the fallopian tubes or completely remove the tubes to ensure that a woman will not become pregnant in the future. When done safely and ethically, sterilization presents a safe and almost 100% effective form of birth control (but offers no protection against STIs and HIV). However, sterilization has a long history of being used as a tool to control or limit population growth in marginalized communities. Because of its dangerous past and permanent nature, enthusiasm for the procedure warrants scrutiny.

The public health sector performs most sterilizations in India with 85% of these taking place in the government sector.[20] Additionally, more than 75% of women get their sterilization free of cost.[21] Spacing methods are obtained primarily in the private medical/health sector. Most users of IUDs, injectables, BCP, and condoms obtain these from a private hospital or pharmacy.

Fact-findings and news reports have confirmed that health workers clearly flaunt government guidelines. For example, in Bundi District, Rajasthan, an NGO found that

18 UN briefing paper on abortion in India, United Nations Population Division, www.un.org/esa/population/publications/abortion/doc/india.doc.

19 *See* Ramakant Rai & Anr. vs. Union of India &Ors., Writ Petition (Civil) 209/2003.

20 *National Family Health Survey (NFHS-3)* 2005-2006, Ministry of Health and Family Welfare, p. 7.

21 *Id.*

out of 749 sterilized women, only 12% were provided pre-surgery counseling regarding alternate forms of contraception.[22] Similarly, 42% of the women said that they were not provided information regarding the permanent nature of sterilization.[23] Every single woman reported that consent forms were not read out or explained to them before a signature or thumb impression was taken.[24]

Before the surgery, government health workers also failed to undertake the 11 mandated pre-sterilization medical screenings.[25] Following the procedure, nearly all of the women were discharged just 4 hours after sterilization.[26] Some of the women (8%) reported that they were not fully conscious at the time of discharge.[27] The NGO looked carefully at Government of India Guidelines and reported that just 13.5% of women were told to rest after their surgery, 18.3% were told to use medicine as advised, and only 4.1% were told to report to the doctor if they experienced discomfort.[28] More than half of the women (58.2%) experienced a negative side effect after sterilization. Nineteen women (2.55%) got pregnant after their sterilizations – a failure rate far above the international standard of 0.5%.[29] As the pending Supreme Court case, *Devika Biswas vs. Union of India & Ors* demonstrates, the facts from Bundi District reveal the dangerous underbelly of "family planning" throughout India.

In sharp contrast to India's current policy, the law conceptualizes family planning through a human rights lens and situates contraceptive choice in the context of expanding women's options, autonomy, and control over their fertility.

## Compounded Discrimination

Maternal mortality, morbidity, and other violations of reproductive rights disproportionately impact poor and marginalized groups. Initially, these women have limited access to health care and antenatal care. In many instances, women in rural areas and heavily populated slums do not receive antenatal care at all. Moreover, reports from states throughout India demonstrate that public hospital workers regularly reject Dalits, members of Scheduled Tribes and Castes, and HIV positive women from delivery rooms.

22 Swarup R Pal, et. al, *Continuing Concerns: An Assessment of Quality Care and Consequence of Female Sterilization in Bundi District of Rajasthan in 2009-10,* Manjari Organization.
23 *Id.*
24 *Id.*
25 *Id.*
26 *Id.*
27 *Id.*
28 *Id.*
29 *Id.*

The United Nations Committee on Economic, Social, and Cultural Rights has expressed its concern about disproportionate rates of malnutrition and Sexually Transmitted Infections (STIs) in Scheduled Tribes and Castes.[30] Likewise, in its 2008 concluding remarks on India, the CESCR Committee encouraged India to increase preventative programs to reduce violence against women members of Scheduled Tribes and Scheduled Castes.[31] Although the Government of India is obligated to create special protections for women in rural areas, the Committee on the Elimination of all forms of Discrimination Against Women found that access to health care, water, and doctors is extremely limited in rural areas.[32] The CEDAW Committee also recommended that the Government of India strengthen enforcement of legal prohibitions of discrimination in health care.

## Child Marriage

According to UNICEF, 47% of girls in India are married by age 18 and 18% of girls are married by age 15.[33] Experts agree that child marriage contributes to poor health indicators, lower levels of education, higher rates of maternal and infant mortality, and increased HIV infection rates. Girls between the ages of 15 and 19 are twice as likely as girls between the ages of 20 and 24 to die of pregnancy related complications.[34] Tradition, honor, gender inequality, security, and socio economic instability perpetuate child marriage. Child marriage persists in the face of the Prohibition of Child Marriage Act (2006).

## Declining Sex Ratio

Sex ratio measures the number of women to men in a population. India's sex ratio for children ages 0 – 6 has set off alarms as most states report sex ratios far below the global average rates of 1,050 girls for every 1,000 boys.[35] The 2011 Census reports an overall sex ratio of 940 girls for every 1,000 boys aged 0 – 6.[36] Haryana (877), Gujarat (918), Punjab (893), Jammu and Kashmir (883), Sikkim (889), and Uttar Pradesh (908) have especially low sex ratios.[37] Many states demonstrated little improvement from the 2001 census, and some states including Jammu and Kashmir, Bihar, and Gujarat actually reported decreases in the number of girls to boys from 2001 to 2011.

30 Concluding Observations of the Committee on Economic, Social and Cultural Rights 40th Session, E/C.12/IND/CO/5, May 2008.

31 *Id.*

32 Concluding Comments on India, Committee on the Elimination of All Forms of Discrimination against Women, 37th Session, CEDAW/C/IND/CO/3, 2 February 2007.

33 UNICEF Statistics, India, 2010.

34 *Pregnant Adolescents: Delivering on Global Promises of Hope,* The World Health Organization, 2006.

35 *Census Highlights Missing Girls,* AFP, 3 April 2011.

36 2011 Census of India, Government of India, 2011.

37 *Id.*

Although there are many explanations for a low sex ratio, experts have concluded that social and economic factors contribute to India's unbalanced numbers. Son preference has been linked to sex selective abortion and female infanticide.

The Government of India has forbidden prenatal and preconception sex determination and promoted cash transfer schemes to parents of newborn girls to improve the sex ratio. Opponents of sex-selective abortion have used the declining sex ratio as a tool to chip away at women's right to a Medical Termination of Pregnancy. Some states have even discussed criminalizing sex-selective abortion. Reproductive rights activists adamantly oppose this move, pointing to the disastrous implications for women and the continued pervasive social norms that perpetuate son preference.

## Maternity Leave, Employment Discrimination

Discrimination against working women continues to create major barriers to reproductive freedom and gender justice. Sexual harassment and gender discrimination persist in both the formal and informal professional sectors.

Although India's current maternity leave law provides women with three months of maternity leave, for millions of women, maternity leave is impossible. Women in the informal employment sector, for example, cannot avail themselves of the rights enumerated in the Maternal Benefit Act because the Act only provides for women working in India's formal employment sector. The last NGO Shadow Report to the Committee for the Elimination of all forms of Discrimination Against Women (CEDAW) states that 87% of women in rural areas work as agricultural laborers in the informal sector. In urban areas, the unorganized sector (garment industry, service sector, construction, domestic work) employs 80% of women.[38] Without adequate leave, employment guarantees, and continued financial support, women working in the informal employment sector put their health and the health of their children at risk.

## Emerging Issues

Crucial reproductive rights issues evolve with developments in technology, legislation, academia, and policy. In the first half of 2012 alone, HRLN conducted fact-finding missions on surrogacy, sex education for adolescents, and malaria and maternal mortality.

HRLN's Reproductive Rights Unit also examines rights that necessarily inform reproductive rights issues including the right to food, the right to shelter, and the right

38 India Second NGO Shadow Report on CEDAW, Coordinated by National Alliance of Women (November 2006).

to reservations for female politicians. Without proper nutrition, a safe living space, or meaningful representation in local government, women cannot exercise their rights to freely and responsibly decide the number and spacing of their children while attaining the highest standard of sexual and reproductive health.

The Government of India and state governments have passed laws and developed schemes to address these reproductive rights issues. The next section of the introduction outlines these protections, policies, and programs.

## Legal Protections and Schemes in India

The Constitution of India provides fundamental protections for all Indians. Most crucially, the Constitution protects the Right to Life and a number of derivative rights, including the right to health and the right to be free from cruel, inhuman, and degrading treatment. The Government of India has also developed a number of specific laws to address reproductive rights issues including child marriage, medical termination of pregnancy, and sex selection.

To correct fundamental rights violations and to improve the reproductive rights situation in India, the Government of India has developed a number of schemes to improve health care, to increase institutional deliveries, and to encourage healthy behavior. Litigation to enforce implementation of these schemes has been an important component of enforcing reproductive rights protections in India. Finally, India is a party to a number of international human rights conventions that obligate the government to protect, promote, respect, and fulfill reproductive rights.

This section of the introduction provides a brief overview of existing legal protections in India.

### Domestic Laws

This section outlines major Constitutional and legislative protections.

#### The Constitution of India

The Constitution of India ensures fundamental rights protections. Reproductive rights cases generally invoke Articles 14, 15, 21, and 51. Specific facts may lend themselves to additional Constitutional provisions or Directive Principles of State Policy.

Article 21 of the Constitution of India guarantees the right to life and personal liberty. The Constitution states: "No person shall be deprived of his or her life or personal liberty except according to procedure established by law." The Supreme Court of India has interpreted Article 21 to include the right to health, the right to be free from torture and inhuman treatment, the right to privacy, and the right to dignity. Many reproductive rights issues have a clear link to entitlements protected under Article 21 of the Constitution. For example, maternal mortality stems from a violation to the right to health and results in a violation of the right to life. If a woman has a forced abortion, she has been subjected to inhuman treatment. If a woman gives birth on the road or in an unhygienic hospital, the government has violated her right to health and dignity.

Article 14 of India's Constitution guarantees "equality before the law or the equal protection of the laws within the territory of India." Article 15 prohibits discrimination "against any citizen on grounds only of religion, race, caste, sex, place of birth, or any of them." Article 15(3) authorizes special provisions for women and children. These Articles ensure equality for all Indians. Because reproductive rights issues disproportionately impact women's lives, health, and status, non-discrimination demands special protections for women throughout the reproductive cycle. Accordingly, inadequate health infrastructure, non-implementation of government schemes, and government inaction disproportionately impact women. Equality and non-discrimination demand protections, meaningful government programs, and access to justice.

Today, Indian jurisprudence widely views reproductive rights as a health rights issue; as such there is a dearth of judgments centered on discrimination. As an exception, the Supreme Court has found that denying maternity benefits constitutes a violation of Article 14.[39] Likewise, the Madras High Court struck down a regulation defining pregnant women as "temporarily unfit for employment" as a violation of Article 14 of the Constitution.[40]

Finally, reproductive rights cases have relied on Article 51 of the Constitution to ensure that the government respects its international reproductive rights obligations. Article 51 provides: "The state shall endeavor to (a) promote international peace and security…(b) to foster respect for international law and treaty obligations in the dealings of organized peoples with one another…" The Supreme Court has referred to Article 51 when affirming India's obligations under international human rights treaties.

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39 *See Municipal Corporation of Delhi vs. Female Workers,* AIR 2000 SC 1274. See the table of contents for the case in this book.

40 *S. Amudha vs. Chairman, Neyveli Lignite Corporation,* IILLJ 234 Mad (1991).

The Constitution of India also includes Directive Principles of State Polity to guide lawmakers at the Centre and state levels. Relevant Directives include:

- Article 21: Right to work, to education, and to public assistance in certain cases;
- Article 42: Provision for just and human conditions of work and maternity leave;
- Article 46: Promotion of educational and economic interests of Scheduled Castes, Scheduled Tribes and other weaker sections;
- Article 47: Announces the State's duty to "raise the level of nutrition and the standard of living and to improve public health."

### Indian Penal Code (1908)

The Indian Penal Code outlines violations including rape and sexual assault (Sections 375-376) and offences causing miscarriages and injuries to unborn children (Section 312). The Medical Termination of Pregnancy Act (MTP, discussed below) is an exception to laws prohibiting harm to the fetus and unborn children.

Other Sections of the Penal Code may also apply to reproductive rights cases. For example, Sections on medical malpractice (52, 80, 81, 83, 88, 92, 304-A, 337, and 338) can be used in cases of maternal mortality, discrimination against HIV positive pregnant women, and cases of botched abortion. Sections pertaining to fraud (Section 420) and consent (Section 90) may likewise be used in coerced sterilization or medical testing cases.

### Maternity Benefit Act (1961)

The Maternity Benefit Act guarantees mandatory maternity leave to all women employed in the government sector. The Act ensures continuation of employment after pregnancy and childbirth and prohibits dismissal of women who avail themselves of maternity leave benefits. Under the Act, women who have returned to work after giving birth have a right to nursing breaks.

The Maternity Benefit Act also allows women to take maternity leave in cases of miscarriage, medical termination of pregnancy, or tubectomy. The Act does not apply to women employed in the informal sector.

### Medical Termination of Pregnancy Act (1971)

The Medical Termination of Pregnancy Act (MTP Act) allows qualified doctors to perform abortions for women in clinics or hospitals. The MTP Act allows abortions for women in specific situations:

- Women whose physical or mental health is endangered by pregnancy;
- Women who will give birth to a handicapped or malformed child;
- Women whose pregnancies are the result of rape;
- Unmarried women under 18 whose parents consent to the abortion;
- Women who are classified as mentally ill whose parents or guardians consent; and
- Women who become pregnant after a failed sterilization surgery.

Women must consent to abortion with certain exceptions. Notably, parents or guardians may consent for minors and mentally ill (but *not* mentally retarded) women. The Act allows abortion up to the 12th week of pregnancy with approval from one registered medical practitioner and then up to the 20th week with approval from two registered medical practitioners. After the 20th week, a registered medical practitioner may only perform a MTP as an emergency measure to save a woman's life.

The MTP Act has been criticized for championing the medical practitioner's opinions over the views of the woman concerned, and litigation has challenged the near total ban on abortions past 20 weeks.

### Prohibition of Child Marriage Act (2006)

The 2006 Prohibition of Child Marriage Act (PCM) repealed the Child Marriage Restraint Act of 1929. In response to a high MMR, civil society activism, litigation, and international attention, the Government of India took a step toward bolstering its child marriage regulations.

The act defines "child" as any male under 21 and any female under 18 years of age. According to the Act, a child marriage occurs when either of contracting parties is a child. The Act allows either child contracting party to void the marriage at any time. The Act also provides for maintenance to a child contracting party.

If a male over 18 contracts a child marriage he will be punished "with rigorous imprisonment which may extend to two years and shall be liable to fine which may extend to one lakh rupees unless he proves that he had reasons to believe that the marriage was not a child marriage."[41] Likewise, parents or guardians who facilitate or who do not prevent child marriages will be punished "with rigorous imprisonment which may extend to two years and shall also be liable to fine which may extend up to one lakh rupees."[42]

41 Prohibition of Child Marriage Act, para.9 (2006).
42 Prohibition of Child Marriage Act, para.11 (2006).

Under the Act, each state government shall appoint Child Marriage Prohibition Officers (CMPOs). These CMPOs prevent child marriages, investigate potential cases of child marriage, advise families, create awareness, sensitize the community, furnish periodical statistics, and perform other necessary tasks. The Act empowers CMPOs to seek an injunction from a Magistrate judge after receiving information about a child marriage.

This law has been criticized because it maintains a gender imbalance regarding the age of adulthood. Additionally, the law only punishes men over 18 who knowingly enter into a child marriage.

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

The Government of India enacted this law to respond to the country's disproportionate sex ratio. First, the Act prohibits genetic laboratories from undertaking any technique that facilitates or causes sex determination (including sperm sorting). Secondly, the Act regulates prenatal diagnostic techniques including ultrasonography to determine the sex of the fetus. To enforce the regulations, the Act relies on reporting from registered testing and genetic facilities.

Under the Act, when "medical geneticists, gynaecolgists, registered medical practitioners or any person who owns a Genetic Counseling Centre, a Genetic Laboratory or a Genetic Clinic or who is employed in such a Centre, Laboratory or Clinic" violates the PCPNDT Act, he or she faces a prison term of up to three years and a fine of up to Rs. 10,000. Multiple offenders receive a prison sentence of up to five years and a fine of up to Rs. 50,000.[43] Additionally, individuals seeking out sex determination face a prison sentence of up to three years and a fine of up to Rs. 50,000. The Act very explicitly states that the punishment will not "apply to the woman who was compelled to undergo such diagnostic techniques or such selection."

It is important to note that the PCPNDT does not mention Medical Termination of Pregnancy. Accordingly, if the sex of the fetus is determined in violation of the law, any subsequent MTP (for whatever reason) will not amount to a punishable offense under the Act. Increasingly, concern surrounding sex ratio and sex selective abortion has encroached on women's rights to exercise their reproductive autonomy. It is crucial to situate sex ratio policy in a rights framework that recognizes, promotes, and respects women's fundamental rights. Although the Government of India passed the PCPNDT Act in 1994, India's sex ratio has not improved and between the 2001 and 2011 censuses, many states actually saw a fall in the number of girls to boys.

43 The Pre-Conception and Pre- Natal Diagnostic Techniques Act, Act No. 57 (1994), para. 23.

## Consumer Protection Act, 1996

The Government of India enacted the Consumer Protection Act to preserve the interests of the public. Specific consumer rights include: the right to be protected against the marketing of goods and services which are hazardous to life and property; the right to be heard and to be assured that consumer's interests will receive due consideration at appropriate forums; the right to seek redressal against unfair trade practices or restrictive trade practices or unscrupulous exploitation of consumers; and the right to consumer education.[44]

Section 2(o) of this Act includes medical services. As a result, medical professionals have an obligation to meet a minimum standard of professional behavior and care. In reproductive rights, non-consensual medical procedures including hysterectomies and tubectomies, substandard care, and unhygienic facilities could require compensation under the Consumer Protection Act.[45]

## Codified and Un-codified Personal Laws

In India, codified personal laws govern 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.

## Protection of Women from Domestic Violence Act 2005

The Protection of Women from Domestic Violence Act defines domestic violence as: habitual assaults, cruelty of conduct not amounting to physical ill-treatment, forcing the victim to lead an immoral life, harassment related to dowry or childbearing, or other harm or injury to the victim. 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.

The Act also guarantees a woman's right to housing in the matrimonial home regardless of her property titles or grants. At the same time, the Act allows the courts to prevent the abuser from contacting the victim, seeing the victim, or isolating the victim's assets.

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44 *Id.*

45 *See, Samira Kohli vs. Dr. PrabhaManchanda and Anr.,*[Appeal (Civil) 1949 of 2004].

### Jurisprudence

The bulk of this book outlines reproductive rights jurisprudence from State High Courts and the Supreme Court of India. In addition to these cases, reproductive rights activists draw on a plethora of judgments relating to the right to health,[46] the right to be free from inhuman, cruel, and degrading treatment,[47] and the right to gender equality.[48] These cases couch the emerging entitlements and freedoms under reproductive rights in more established law.

### State Level Laws

In addition to national laws and Supreme Court jurisprudence, individual states may have their own laws, High Court jurisprudence, and specific schemes that impact public health and reproductive rights. For example, in 2010, the Government of Assam adopted the Assam Public Health Bill "to protect and fulfill rights in relation to health and well-being, health equity and justice, including those related to all the underlying departments of health as well as health care and for achieving the goal of health for all…"[49]

State laws can also block groups from exercising their reproductive rights. States including Rajasthan, Chhattisgarh, Madhya Pradesh, and Uttar Pradesh have completely outlawed sex education. Accordingly, adolescents do not have access to basic necessary information on their bodies, reproduction, or sexual health. Similarly, some states stand by the two child norm with disastrous implications for women and families who lose out on entitlements, professional opportunities, and health care when they have more than two children.

## National Schemes and Policies Related to Reproductive Rights

Because reproductive rights have largely been situated in the right to health, most relevant schemes and government programs directly address the public health system. For example, to combat its staggering MMR, the Government of India initiated and

46 *See e.g., State of Punjab vs. Mohinder Singh Chawla* 1997 (2) SCC 83; *Francis Coralie Mullin vs. Union Territory of Delhi & Ors*, 1981 SCR (2) 516; *Consumer Education and Research Center vs. Union of India,* 1995 SCC (3) 43; *Paschim Banga Khet Mazdoor Samity vs. State of West Bengal* 36, 1996 (4) SCC 37.

47 *See* (be consistent with your Sees. Some are italicized and others are not) *Francis Coralie Mullin vs. Union Territory of Delhi & Ors*, 1981 SCR (2) 516.

48 *Apparel Export Promotion Council vs. Chopra*, AIR 1999 SC 625, *holding, "gender equality is one of the most precious Fundamental Rights guaranteed by the Constitution of India."*

49 The Assam Public Health Bill, 2010.

revamped various schemes to encourage maternal health care, to increase institutional deliveries, and to bolster nutrition for pregnant and lactating women.

Many of the cases in this book refer to the government schemes outlined below:

## The National Rural Health Mission (NRHM)

The Government of India launched the National Rural Health Mission (NRHM) in 2005 with the goal of "improv[ing] the availability of access to quality health care by people, especially for those residing in rural areas, the poor, women and children through equitable, affordable, accountable and effective primary healthcare."[50] The NRHM requires the Government to increase public health expenditures, to encourage community participation, and to reduce regional imbalances. The NRHM also obligates states to reduce their MMRs to 100 for 100,000 live births. Notwithstanding, India is far from meeting its NRHM mandated MMR goal. At the end of the last five-year NRHM period, the government announced its intention to convert the NRHM into the National Health Mission - a scheme that would also cover India's urban poor.

The programme creates a tiered system to deliver maternal and child health services to all communities. Each level of care has obligations outlined below:

### A. Sub Health Centre (SHC):

1. Early registration of all pregnancies, ideally within the first trimester;
2. Minimum of four antenatal check-ups: First visit to the antenatal clinic as soon as pregnancy is suspected, second between fourth and sixth month (around 26 weeks), and fourth and ninth month (around 36 weeks);
3. Associated general services such as collection of weight and blood pressure;
4. Provision of supplements including folic acid beginning in the first trimester and iron beginning in the second trimester;
5. Vaccines including an injection of tetanus toxoid;
6. Treatment of anaemia;
7. Identification of high-risk pregnancies and appropriate and prompt referral; and
8. A minimum of two postpartum home visits, first within 48 hours of delivery, second within 7-10 days.

50 *Framework for Implementation,* The National Rural Health Mission, 2005-2012, p. 8.

### B. Primary Health Centre (PHC):

1. All services available at SHCs;
2. Janani SurakshaYojana (JSY, discussed below) implementation;
3. 24-hour emergency care including delivery services for both normal and assisted deliveries; and
4. Full coverage of maternal diseases/health conditions;
5. Postnatal care including initiation of early breastfeeding and minimum of two postpartum home visits;
6. Range of family planning including contraceptives, tubal ligation, counseling and appropriate referral for safe abortion services;
7. Referral services including transport either by PHC vehicle or hired vehicle. The Government will cover the cost of transportation.

### C. Community Health Centers (CHC):

1. All services available at PHCs;
2. Essential and emergency obstetrics care;
3. Full range of family planning services;
4. Safe abortion services;
5. Blood bank facility;
6. Essential laboratory services; and
7. Implementation of all National Health Programmes.

Activists have noted gapping holes in NRHM implementation across India. Many facilities remain far below Indian Public Health Standards (IPHS) and lack staff and equipment. The Government of India rolled out the NRHM without ensuring the infrastructure needed to support the massive health program. The cases in this book illustrate the disastrous implications of the states' failure to fully implement the guarantees in the NRHM.

### Janani Suraksha Yojana (JSY)

JSY comprises a core component of the NRHM and aims to reduce maternal mortality by encouraging institutional deliveries. The program "is a 100% centrally sponsored

scheme and it integrates cash assistance with delivery and post-delivery care."[51] This scheme provides financial assistance to Below the Poverty Line (BPL), Scheduled Caste, and Schedule Tribe women who obtain antenatal care, undergo institutionalized delivery, and seek postpartum care. After delivery, women receive a cash incentive of Rs. 600 to Rs. 1,400 (depending on the state and rural/urban area).[52]

Under JSY, Accredited Social Health Activists (ASHAs) are assigned to every village to work closely with pregnant women. ASHAs serve as a link between the Government and pregnant women. An ASHA's key responsibilities include:

- Identify pregnant women as beneficiaries of the scheme and report or facilitate registration for antenatal care (ANC). This should be done at least 20-24 weeks before the expected date of delivery;
- Assist the pregnant woman to obtain necessary certification wherever necessary, within 2-4 weeks of registration;
- Provide and/or help the woman in receiving at least three ANC checkups including TT injections, IFA tablets;
- Prepare a micro birth plan;
- Identify a functional Government health center or an accredited private health institution for referral and delivery, immediately upon registration;
- Counsel for institutional delivery;
- Escort the beneficiary woman to the pre-determined health center and stay with her until she is discharged;
- Arrange to immunize the newborn till the age of 14 weeks;
- Inform the ANM/Medical Officer (MO) about the birth or death of the child or mother;
- Perform a post-natal visit within 7 days of delivery to track the mother's health after the delivery and facilitate it in obtaining care, whenever necessary;
- Counsel for initiation of breast-feeding to the newborn within one hour of delivery and its continuance till 3-6 months and promote family planning; and
- Facilitate the payment of financial assistance immediately following the delivery.[53]

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51 *Janani Suraksha Yojana, Features and Frequently Asked Questions and Answers,* Ministry of Health and Family Welfare, Government of India, October 2006.

52 *Id.*

53 *Id.*

Under JSY and the NRHM, institutionalized births in India have sharply increased. In an overwhelming number of field interviews, women explain that they travel to public health facilities to give birth under the watch of skilled medical professionals. Unfortunately, hospitals, CHCs, and PHCs are not equipped to handle the rising wave of delivering women. Hospitals are woefully understaffed and undersupplied. As a result of staff shortages and negligence, the cleaning staff performs deliveries in some hospitals. Hospitals habitually refer delivering women, resulting in additional travel time and enormous personal expenses for poor families. As the United Nations Special Rapporteur on the Right to Health, Paul Hunt observed, pushing women into inadequate institutions robs them of their basic human dignity, puts their health at risk, and amounts to a grave injustice.[54]

## National Maternal Benefit Scheme (NMBS)

The NMBS provides cash assistance of Rs. 500 to pregnant women from Below Poverty Line (BPL) families. The Government designed the NMBS to ensure that pregnant BPL women have access to food and nutrition leading up to delivery. Although the Union of India has claimed that JSY subsumes NMBS, on 20 November 2007, the Supreme Court held that "The Union of India and all the State Governments…shall (i) continue with the NMBS and (ii) ensure that all BPL pregnant women get cash assistance 8-12 weeks prior to delivery."[55] The Court has also held that all BPL women have a right to Rs. 500 per birth regardless of the mother's age or number of children.

## Janani Shishu Suraksha Karyakram (JSSK)

The JSSK scheme pledges to provide women who deliver in government hospitals with free medical care, diagnostic services, blood supplies, medicines, food, and travel.[56] Under this heavily subsidized system, all delivery services including normal delivery and Cesarean-Section (C-Section) surgeries will be totally free. Additional care services are available to the mother for 42 days following the birth and for the newborn for 30 days following delivery. Given the current culture of corruption and massive out of pocket expenditures families face during delivery, many health activists are doubtful about the effective implementation of this scheme.

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54 Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health*, UN Doc. A/HRC/14/20/Add.2, 15 April 2010, p. 13, para 51.

55 *See* Supreme Court Judgment in *People's Union for Civil Liberties (PUCL) vs. Union of India & Ors,* Writ Petition (C) 196/2011 (11 November 2007). *See also Response to Application of Ministry of Health and Family Welfare of India (IA No.92) for directions regarding implementation of Janani Suraksha Yojana* (5 April 2010); http://www.sccommissioners.org/

56 *Guidelines for Janani-Shishu Suraksha Karyakram (JSSK),* National Rural Health Mission, Ministry of Health and Family Welfare, Government of India (2011).

## Integrated Child Development Services Scheme (ICDS)

The Integrated Child Development Services (ICDS) Scheme works to combat malnutrition, morbidity, reduced learning capacity, and mortality in early childhood. [57] Since 1975, ICDS has provided a package of services including supplementary nutrition, immunization, health check-ups, referral services, pre-school non-formal education, and nutrition and health education. These services are delivered at locally designated Anganwadi Centers (community-based child-welfare centers). Additionally, all women between 15 and 45 years of age receive nutrition supplements and health education under ICDS.

Auxiliary Nurse Midwives (ANMs), ASHAs, Medical Officers, and Anganwadi Centre Workers are chiefly responsible for implementing the scheme. Children, severely malnourished children, and pregnant and lactating women receive a cash benefit and supplementary nutrition in the form of take home rations or hot cooked meals.

In the ongoing Right to Food Case, *PUCL vs. Union of India & Ors. (W.P. (C) 196/2001),* the Supreme Court has issued numerous orders concerning implementation of the ICDS Scheme. In 2004 the Court held that BPL status is not a requirement for accessing the entitlements under ICDS.[58]

## Private Sector

Increasingly, the private sector has taken advantage of gaps in public health care. 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 Yojna (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 privatisation of the health service in the State party, impacting in particular on the poorest sections of the population…"[59]

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57 *Integrated Child Development Services Scheme* (ICDS), Ministry of Women and Child Development, Government of India (1975).

58 *See* Supreme Court Judgment in *People's Union for Civil Liberties (PUCL) vs. Union of India &Ors,* Writ Petition (C) 196/2011 (7 October 2004); *See also* http://www.sccommissioners.org/

59 Concluding Comments on India, Committee on Economic, Social and Cultural Rights, 40th Session, E/C.12/IND/CO/S(2008), May 2008.

## International Law

As a signatory to international conventions spanning a wide variety of human rights, India has a legal duty to protect, promote, and respect reproductive rights. The Center for Reproductive Rights in New York has identified 12 internationally recognized human rights encompassed in reproductive rights.[60] This section outlines these rights and the relevant articles and jurisprudence from international human rights mechanisms. This section also provides information on India's ratification of each international convention.

The Supreme Court constantly confirms India's international human rights obligations. In *Apparel Export Promotion Council vs. Chopra (1999),* the Hon'ble Court found that the judiciary "is under an obligation to give due regard to international Conventions and Norms for construing domestic laws more so when there is no inconsistency them and there is a void in domestic law.[61] Article 51 of the Constitution of India confirms the importance of ensuring respect for international law and treaties.

### International Conventions:

*This section refers to the following international human rights conventions:*

- CERD: Convention on the Elimination of Racial Discrimination, 1965, signed by India on 2 March 1967, ratified by India on 3 December 1968.
- ICCPR: International Covenant on Civil and Political Rights, 1966, signed by India on 30 December 1992, ratified by India on 22 August 1979.
- ICESCR: International Covenant on Economic, Social, and Cultural Rights, 1966, acceded to by India on 19 April 1979.
- CEDAW: Convention on the Elimination of all forms of Discrimination Against Women, 1979, signed by India on 30 July 1980, ratified by India on 9 July 1993.
- UNCAT: United Nations Convention Against Torture, 1987 signed by India on 14 October 1997 (not ratified by India).
- CRC: Convention on the Rights of the Child, 1989, acceded to by India on 11 December 1992.
- CRPWD: Convention on the Rights of Persons With Disabilities, 2006, signed by India on 20 March 2007, ratified by India on 1 October 2007.

This section also refers to the Programme of Action from the United Nations International Conference on Population and Development (ICPD, 1994), a non-legally binding agreement 179 states, including India, pledged to uphold.

60 *Reproductive Rights are Human Rights*, Center for Reproductive Rights (2009).
61 *Apparel Export Promotion Council vs. Chopra*, AIR 1999 SC 625.

These Conventions and International documents form the legal basis for the package of fundamental rights encompassed in reproductive rights. The following sections comprise a very brief introduction to these international obligations.

## 1. The Right to Life

Like Article 21 of the Indian Constitution, international human rights conventions recognize the right to life. Article 6(1) of the International Covenant on Civil and Political Rights (ICCPR) states, "Every human being has the inherent right to life. This right shall be protected by law." Likewise, Article 6(1) of the Convention on the Rights of the Child (CRC) "recognize[s] that every child has the inherent right to life." The Program of Action the United Nations International Conference on Population and Development also recognizes the right to life.[62]

Every year, millions of women die when their reproductive rights to maternal health care, safe abortion services, and adequate health care are violated. These largely preventable deaths amount to a violation of the fundamental right to life. India loses the potential contributions of millions of women as a result of maternal mortality and morbidity. International treaty bodies and judicial organs have increasingly articulated the links between reproductive rights and the right to life. For example, the United Nations Population Fund (UNPF) has repeatedly recognized that barriers to contraception perpetuate pregnancy related deaths.

The same is true for international human rights jurisdictions. For instance, in 2010, the Inter-American Court of Human Rights held that maternal death constitutes a human rights violation. In *Xákmok Kásek Indigenous Community vs. Paraguay* the Inter-American Court of Human Rights found a violation of the right to life where a 38-year-old woman died when she did not receive medical attention during labor.[63] The Court also recognized the link between poverty and maternal death. In the same year, the Delhi High Court became the first national high court in the world to hold that maternal mortality is a violation of a woman's right to life.[64]

## 2. The Right to Liberty and Security of Person

International conventions also guarantee the right to liberty and security of person. This includes the right to be free from violence including non-consensual medical treatment. In the context of reproductive rights, liberty and security of person preserves the rights of women to make choices about their sexuality and reproductive lives without coercion,

62 *See* Reproductive Rights and Reproductive Health, International Conference on Population and Development, Cairo, 1994, principle 1.

63 Xakmok *Kasek vs. Paraguay*, Judgment (IACtHR), *24 Aug. 2010.*

64 *See* the section on *Laxmi Mandal vs. Deen Dayal Harinagar Hosptial & Ors* (W.P. (C) 8852/2008).

violence, or discrimination. Forced or coerced sterilization, discriminatory population control policies, and restrictions on reproductive autonomy violate the Right to Liberty and Security of Person.

The ICCPR guarantees the right to liberty and security of person in Article 9(1). The Convention on the Rights of Persons with Disabilities (CRPWD) also confers this right in Article 14.

Principle 1 of the ICPD also underscores the right to life, liberty, and security of person. The Programme of Action specifies, "Governments at all levels are urged to institute systems of monitoring and evaluation of user-centered services with a view to detecting, preventing, and controlling abuses by family-planning managers and providers…" To this end, Governments should secure conformity to human rights and to ethical and professional standards in the delivery of family planning and related reproductive health services aimed at ensuring responsible, voluntary and informed consent and also regarding service provision.[65]

In this context, the two-child norm, sterilization targets and incentives, and inadequate informed consent constitute violations of the right to liberty and security of the person.

### 3. The Right to Health, including the Right to Sexual and Reproductive Health

In many jurisdictions, the right to health forms the backbone of reproductive rights litigation and advocacy. In India, limited access to inadequate health care results in maternal mortality and morbidity, botched abortions, forced sterilization, limited contraceptive choices, medically unnecessary surgeries, increased HIV infections, and even death.

The right to health must be measured along Availability, Accessibility, Acceptability, and Quality (AAAQ) standards. Facilities, goods, programs, and essential drugs should be available. Sexual and reproductive health information, access to clean water, literacy, nutrition, gender equality, and participation in health-related decisions also comprise key components of the Availability standard.

Accessibility means non-discrimination to marginalized sections of society, physical accessibility of health services and underlying determinants of health, affordability, and access to information.

65 Reproductive Rights and Reproductive Health, International Conference on Population and Development, Cairo, 1994, para. 7.17.

Acceptability means health services are culturally and gender-sensitive. Acceptable care also includes respect for confidentiality and basic standards of hygiene and care.

Quality measures whether care is scientifically and medically appropriate and of good standards.

Each of these standards is breached in India's maternal mortality cases. Marginalized women cannot avail themselves of antenatal care or basic information about delivery and health. When they go into labor, they travel for hours on dangerous roads to reach public health facilities lacking medical infrastructure, minimum standards for respecting patients, and good quality care.

The CRC (Article 24), CRPWD (Article 25), and Convention against Racial Discrimination (CERD) (Article 5) guarantee the right to health. Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR) provides that States Parties will:

1. Recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
   (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
   (b) The improvement of all aspects of environmental and industrial hygiene;
   (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
   (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

In General Comment No. 14, the Committee on Economic, Social, and Cultural Rights clarifies that the right to health does not amount to the right to be healthy. Instead, the right to health encompasses freedoms such as the right to control one's body, the right to reproductive choice, and the right to be free from torture. The right to health also includes entitlements such as a system of health protection that provides "equality of opportunity for people to enjoy the highest attainable standard of health."[66] Reproductive rights mirror the dual nature of the right to health outlined in the ICESCR, with the right

66 Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4 (2005).

to freedoms like reproductive self-determination and bodily integrity *and* entitlements like access to acceptable health care providers and information.

ICPD Paragraph 7.2 defines reproductive health as "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 to its functions and processes."[67]

The ICESCR and CEDAW specifically address women's right to health. Article 10(2) of the ICESCR obligates States Parties to provide women with special protections before and after childbirth. Likewise, CEDAW guarantees the right to health in Articles 12 and 14. Article 12 of CEDAW requires States Parties "to 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." Moreover, Article 12(2) demands that States Parties "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, guaranteeing free services where necessary, as well as adequate nutrition during pregnancy and lactation."[68]

In *A.S. vs. Hungary,* the Committee for the Elimination of all forms of Discrimination Against Women found that Hungary violated Article 12 CEDAW where doctors performed a nonconsensual sterilization surgery on a marginalized Roma woman.[69] In determining whether Hungary violated the Convention, the Committee considered A.S.'s total experience in the hospital, exploring both her rights to bodily integrity and entitlements to adequate care:

> "The Committee takes note of the author's description of the 17-minute timespan from her admission to the hospital up to the completion of two medical procedures. Medical records revealed that the author was in a very poor state of health upon arrival at the hospital; she was feeling dizzy, was bleeding more heavily than average and was in a state of shock. During those 17 minutes, she was prepared for surgery, signed the statements of consent for the caesarean section, the sterilization, a blood transfusion and anesthesia and underwent two medical procedures, namely, the caesarean section to remove the remains of the dead fetus and the sterilization.

67 Reproductive Rights and Reproductive Health, International Conference on Population and Development, Cairo, 1994, para. 7.2.

68 Committee on the Elimination of Discrimination Against Women, *General Recommendation No. 24, Article 12 of the Convention (Women and Health)* U.N. Doc. CEDAW/A/54/38/Rev.1, para. 17 (1999).

69 *A.S. vs. Hungary,* Committee on the Elimination of Discrimination Against Women, CEDAW/C/36/D/4/2004 (2006).

> The Committee further takes note of the author's claim that she did not understand the Latin term for sterilization that was used on the barely legible consent note that had been handwritten by the doctor attending to her, which she signed."[70]

Likewise, lawyers and activists should examine and look for violations throughout a woman's entire experience with health care. Women and adolescents in India have the right to the highest attainable standard of health and reproductive health at every stage of life, regardless of social class, religion, or location.

## 4. The Right to Freely Decide Number and Spacing of Children

The right to freely plan one's family is a keystone of reproductive rights. To make decisions regarding family size, individuals must have access to health care, education, contraception, and a discrimination-free environment. Article 16 of CEDAW underscores this fundamental component of reproductive rights:

- Article 16(1) States Parties 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…

This right is closely related to ICCPR Article 17, which guarantees everyone the right to be free from "arbitrary or unlawful interference with his privacy, family, home, or correspondence, nor to unlawful attacks on his honor or reputation." Likewise, Article 23 of the CRPWD contains similar language guaranteeing persons with disabilities the right to freely decide the number and spacing of their children.

The fundamental right to freely determine the number and spacing of one's children is especially crucial for women as childbearing has a disproportionate impact on women's mental and physical health, access to education, employment opportunities, and personal development.[71] To fulfill this right, states must supply women with sex education, contraceptives, and access to safe abortion.

With rare exceptions, women, not husbands, fathers, family members, or doctors should provide consent for reproductive rights choices. In *A.S. vs. Hungary* (discussed under the Right to Health), the Committee on the Elimination of all forms of Discrimination

70 *Id.*

71 Committee on the Elimination of all forms of Discrimination Against Women, *General Recommendation No. 21, Equality in marriage and family relations,* A/49/38 (13th Session, 1994).

against Women found that Hungary also violated Article 16 based on CEDAW General Recommendation 19 which states: "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."[72]

In 2005, the United Nations Human Rights Committee decided that inadequate access to abortion services violates women's rights[73] and the European Court of Human Rights has consistently found that barriers to legal abortion prohibit women from accessing their human rights.[74]

To exercise the right to decide the number and spacing of children, women must have access to available, acceptable, quality services (abortion, contraception, medical care) and the information, freedom, and technology to enable/exercise those decisions.

## 5. The Right to Consent to Marriage and Equality in Marriage

The right to freely enter into marriage and to equality within that unit has significant implications on important reproductive issues including child marriage, family planning decisions, and access to health care. Four major human rights conventions guarantee the right to freely enter into marriage and obligate States Parties to ensure that men and women have equal rights within the family unit.

In Article 23, the ICCPR ensures that "the right of men and women of marriageable age to marry and found a family shall be recognized." Additionally, Article 23(3) specifies, "No marriage shall be entered into without the free and full consent of the intending spouses." Finally, Article 23(4) states, "States Parties…shall take appropriate steps to ensure equality of rights and responsibilities of spouses as to marriage, during marriage and at its dissolution." The ICESCR also protects the right of individuals to enter into marriage freely (Art. 10(1)), while the CRPWD protections resemble the more comprehensive list in CEDAW.

Article 16 (1) of CEDAW obligates States Parties to,

> Take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family matters and in particular shall ensure, on a basis of equality of men and women

72 Committee on the Elimination of all forms of Discrimination Against Women, *General Recommendation No. 19, Violence against women*, A/47/38 (11th Session, 1992).

73 *KL vs. Peru*, Human Rights Committee, UN Doc CCPR/C/85/D/1153/2003 (22 November 2005).

74 *See e.g. Tysiac vs. Poland,* European Court of Human Rights, Application No. 5410/03 (2007); *ABC vs. Ireland,* European Court of Human Rights, Application No.25579/05 (2010).

a. The same right to enter into marriage;
b. The same right freely to choose a spouse and to enter into marriage only with their free and full consent;
c. The same rights and responsibilities during marriage and at its dissolution;
d. The same rights and responsibilities as parents, irrespective of their marital status, in matters relating to their children; in all cases the interests of the children shall be paramount;
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;
f. The same rights and responsibilities with regard to guardianship, wardship, trusteeship and adoption of children, or similar institutions where these concepts exist in national legislation; in all cases the interests of the children shall be paramount;
g. The same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation;
h. The same rights for both spouses in respect of the ownership, acquisition, management, administration, enjoyment and disposition of property, whether free of charge or for a valuable consideration.

Article 16(2) of CEDAW addresses child marriage, "The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory."

The Government of India signed and ratified CEDAW with a declaration to Article 16. Unlike reservations, declarations do not change a Government's legal obligations under the convention. Declarations simply clarify a signing government's interpretation of specific articles. India's Article 16 declaration announces:

"i) With regard to articles 5 (a) and 16 (1) of the Convention on the Elimination of All Forms of Discrimination Against Women, the Government of the Republic of India declares that it shall abide by and ensure these provisions in conformity with its policy of non-interference in the personal affairs of any Community without its initiative and consent.

ii) With regard to article 16 (2) of the Convention on the Elimination of All Forms of Discrimination Against Women, the Government of the Republic of India declares that though in principle it fully supports the principle of compulsory registration of marriages, it is not practical in a vast country like India with its variety of customs, religions and level of literacy."

This declaration does not change the Government of India's basic obligation to ensure women's fundamental rights within the family unit.

## 6. The Right to Privacy

Along with the right to health, the right to privacy has been a successful legal basis for violations of reproductive rights. Although Courts from diverse jurisdictions have held that the right to privacy includes the right to make personal decisions regarding family and health, Indian Courts have been reluctant to broaden this right to include reproductive choice. International human rights mechanisms including the ICCPR (Article 17(1)), CRC (Article 16(1)), and CRPWD (Article 22(1)), contain protections against arbitrary or unlawful interferences with privacy, family, home or correspondence.

In 2011, the United Nations based Human Rights Committee (HRC) found a violation of the right to privacy where a lower court in Argentina prohibited a mentally disabled rape victim from obtaining an abortion. In *LMR vs. Argentina*, the HRC concluded that the judiciary intervened in a decision that should have been a private matter between the woman and her physician.[75] Other jurisdictions have examined privacy within the sphere of the family. The European Court of Human Rights found that inadequate procedures for challenging restrictions to abortion services violated Article 8 (respect for private and family life) of the European Convention of Human Rights.[76]

In *Gobind vs. State of M.P.*, the Supreme Court of India has held that "individual autonomy, perhaps the central concern of any system of limited government, is protected in part under our Constitution by explicit constitutional guarantees….Many of the fundamental rights of citizens can be described as contributing to the right to privacy."[77] The Court sites the ICESCR and cases from the United States Supreme Court including *Roe vs. Wade,* a case about the right to abortion. Ultimately, the Court held, "any right to privacy must encompass and protect the personal intimacies of the home, the family, marriage, motherhood, procreation and child rearing."[78] In *Rajgopal vs. Tamil Nadu*, the Supreme Court reaffirmed that every citizen has "a right to safeguard the privacy of his own family, marriage, procreation, motherhood, child-bearing and education."[79]

In the landmark Delhi High Court decision *Naz Foundation vs. Government of New Delhi & Ors.* (W.P. (C) 7455/2001), the Court expanded the notion of privacy under Article 21 of the Constitution of India. The High Court cited Article 17 of the International

75 *See LMR vs. Argentina,* Human Rights Committee, CCPR/C/101/D/1608/2007 (28 April 2011).
76 *Tysiac vs. Poland,* European Court of Human Rights, Application No. 5410/03 (2007).
77 *Gobind vs. Madhya Pradesh* 2 SCC 148 (1975).
78 *Id.*
79 *Rajgopal vs. Tamil Nadu,* 6 SCC 632 (1994).

Covenant of Civil and Political Rights, which guarantees the right to be free from "arbitrary or unlawful interference with…privacy, family, home and correspondence…" The Delhi High Court also cited myriad reproductive rights cases from the United States including *Griswold vs. State of Connecticut*[80] (The decision to use contraception falls within a family's constitutionally protected right to privacy), *Eisenstadt vs. Baired*[81] (Unmarried people have a right to contraception because they have a right "to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."), *Roe vs. Wade*[82] (Although the US Constitution does not explicitly mention privacy, bans on abortion violate certain zones of privacy guaranteed in the Constitution.), and *Planned Parenthood of Southeastern PA vs Casey*[83] (Family planning decisions "are central to the liberty protected by the Fourteenth Amendment.")

In light of this comparative jurisprudence, international law, and Indian Supreme Court cases including Gobind, the High Court held that criminalizing "consensual sexual acts of adults in private" violates Articles 14, 15, and 21 of the Constitution.

Privacy and familial autonomy present an opportunity for reproductive rights activists to explore new terrain for litigation.

## 7. The Right to Equality and Non-Discrimination

The right to be free from discrimination based on a wide range of identities forms an essential basis for human rights. The right to be free from discrimination obligates states to abolish discriminatory practices and laws. At the same time, to achieve equality, states may need to make special laws or policies that primarily impact one group of people. For example, maternity leave benefits for pregnant women aim to correct the imbalance created when professional women make the choice to have a child.

In the reproductive rights context, the right to equality and non-discrimination requires states to ensure that all women enjoy the same rights, opportunities, and benefits as men. At the same time, equality and non-discrimination in reproductive rights demands states to take corrective measures including special health care schemes for women, incentive schemes for girl children, and maternity leave.

Discrimination has many facets and women often find themselves at the intersection of gender and disability, gender and class, or gender, race, religion, and ethnicity. International

80 *Griswold vs. State of Connecticut*, 381 US 479 (1965).
81 *Eisenstadt vs. Baired,* 405 US 438 (1972).
82 *Roe vs. Wade,* 410 US 113 (1973).
83 *Planned Parenthood of Southeastern PA vs. Casey*, 505 US 833 (1992).

law has recognized the myriad faces of discrimination. For example, CEDAW makes special considerations for rural women.[84] The ICESCR and CEDAW Committees have said that special care and consideration should be given to these women. Compounded discrimination is a crucial component of many reproductive rights violations.

The ICCPR, ICESCR, CEDAW, CRC, CRPWD, and CERD all guarantee the right to equality and non-discrimination.

Article 2 of both the ICCPR and ICESCR obligate States Parties to ensure that the rights enshrined in each Covenant will be respected regardless of race, color, sex, religion, political or other opinion, property, birth, or other status. Similarly, Article 2 of the CRC protects children from discrimination based on identity or on their parents' identities. In Article 6 (1), the CRPWD recognizes the combined discrimination women and girls with disabilities face and demands that states undertake measures to ensure "the full and equal enjoyment by them of all human rights and fundamental freedoms." Finally, Article 1(1) of CERD defines racial discrimination and allows for special measures aimed at protecting or advancing marginalized racial groups 1(4).

CEDAW also contains numerous protections against discrimination. Article 1 defines discrimination against women:

> Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Article 3 of CEDAW obligates States Parties to adopt legislation or alternative measures "to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men." States are therefore obligated to do more than just end discrimination; they must take meaningful steps to usher in equality.

Finally, Article 11 of CEDAW protects women's rights to non-discrimination in the work place and provides directions to states to ensure women's effective right to work by introducing maternity leave schemes and prohibiting dismissal on the basis of pregnancy.

In August 2011, the UN Committee on the Elimination of Discrimination Against Women decided its first maternal mortality case and found that Brazil violated Articles

84 CEDAW, Article 14.

2 and 12 in conjunction with Article 1 of CEDAW where the state failed to prevent Alyne da Silva's maternal death.[85] In addition to addressing the right to maternal health care, state responsibility for private providers, access to judicial remedies, and the state's obligation to implement public health programs, the Committee underscored the compounded discrimination Alyne da Silva faced as a poor woman of African descent.

## 8. The Right to be Free from Practices that Harm Women and Girls

While this right is closely linked to the right to equality and non-discrimination, it targets specific practices like child marriage that have a disproportionately negative impact on women and girls. CEDAW Article 2(f) "requires States Parties to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women..." Furthermore, Article 5(a) speaks directly to these cultural patterns and traditions that harm women:

5. States Parties shall take all appropriate measures:

a. To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;

b. To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it being understood that the interest of the children is the primordial consideration in all cases.

The CRC, Article 24.3, states that States Parties to the Convention "shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children." In addition to child marriage, cultural taboos around menstruation, reproduction, and sexuality also limit girls, adolescents, and women's access to basic human rights to health, information, and reproductive autonomy.

## 9. The Right Not to be Subjected to Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment

Article 7 of the ICCPR ensures, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." Likewise, Article 37 of the CRC prohibits subjecting children to cruel, inhuman or degrading treatment or punishment

85 *Alyne da Silva Pimentel Teixeria vs. Brazil,* Committee on the Elimination of Discrimination Against Women, CEDAW/49/D/17/2008 (10 August 2011).

and Article 15 of the CRPWD states: "In particular, no one shall be subjected without his [or her] free consent to medical or scientific experimentation".

In the context of reproductive rights, examples of violations include cases where women are forced into abortion or where both men and women are forced into sterilization against their will. In General Recommendation 28 on Article 3 (equality of rights between men and women), the Human Rights Committee notes that forced sterilization and abortion fall under the definition of torture or cruel, inhuman, or degrading treatment protected under Article 7 of the ICCPR:

> To assess compliance with article 7 of the Covenant...the Committee needs to be provided with information on national laws and practices with regard to domestic and other types of violence against women, including rape (...). The States Parties should also provide the Committee with information on measures to prevent forced abortion or forced sterilization.[86]

Denial of abortion services is also considered a violation of the right to be free from cruel, inhuman, and degrading treatment. In the UN HRC decision discussed in the section on the right to privacy, Argentina violated Article 7 of the ICCPR where LMR could not access a timely abortion after being raped by her uncle.[87]

Where maternal mortality is concerned, activists and advocates are increasingly including violations of the right to be free from cruel, inhuman, degrading treatment in their legal briefs. When a woman faces excruciating physical pain, severe loss of dignity, or cruelty from medical experts, the suffering amounts to cruel, inhuman, and degrading treatment.

International and domestic sources of law also consider violations of this right as crimes against humanity. For example, the Peruvian state has recently announced that it would reopen an Inter-American Commission on Human Rights (IACHR) friendly settlement, *Maria Mamerita Mestanza Chavez vs. Perú*[88], a case concerning the coerced sterilization and the subsequent death of Ms. Chavez, an indigenous woman. The Government of Peru will now consider Ms. Chavez's case and all other cases of forced sterilization as crimes against humanity.

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86 Human Rights Committee, *General Comment 28: Equality of Rights Between Men and Women* (Article 3), U.N. Doc. CCPR/C/21/Rev.1/Add.10 (Mar. 29, 2000).

87 *See LMR vs. Argentina,* Human Rights Committee, CCPR/C/101/D/1608/2007 (28 April 2011).

88 *Francis Coralie Mullin vs. Administrator, Union Territory of Delhi & Ors.,* 2 SCR 516, 1981.

Reproductive-rights based violations of the right to be free from torture and inhuman treatment can also constitute violations of international humanitarian and international criminal law. For instance, Article 7 of the Rome Statute for the International Criminal Court (ICC) defines crimes against humanity including forced pregnancy and enforced sterilization (Article 7(1)(g). Article 8's list of war crimes includes: "…enforced prostitution, forced pregnancy…enforced sterilization, or any other form of sexual violence also constituting a grave breach of the Geneva Conventions."

In Indian law, the Supreme Court has held that Article 21 includes the right "to protection against torture, or cruel, inhuman, or degrading treatment which is enunciated in Article 5 of the United Nations Declaration of Human Rights and the International Covenant on Civil and Political Rights…"[89]

## 10. The Right to be Free from Sexual and Gender-Based Violence

The Right to be free from torture or cruel, inhuman, or degrading treatment is closely linked to the right to be free from sexual and gender-based violence. This protection also recognizes violence that specifically targets women. Although CEDAW does not contain a specific prohibition of violence against women, Article 5(a) (discussed above) requires States Parties to take appropriate actions to eliminate "prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women." Article 5 aims to deconstruct the social norms that perpetuate violence against women. For reproductive rights, this violence manifests as forced sterilization, forced pregnancy, forced abortion, and delivering in deplorable conditions.

The United Nations Special Rapporteur on Violence against Women declared that policies that impact reproductive rights, including forced sterilization, constitute violence against women.[90] Specifically, the Special Rapporteur found that forced sterilization "essentially involves the battery of a woman [and violates] her physical integrity and security."[91]

Unlike CEDAW, the CRPWD, does specifically prohibit gender-based violence against persons with disabilities in Article 16(1).

89 *Id.*

90 *Report of the Special Rapporteur on Violence against Women, its Causes and Consequences*, UN Doc. E/CN.4/1999/68/Add.4 (1999).

91 *Id.*

International law also protects women, children, and persons with disabilities from trafficking and sexual exploitation. Article 6 of CEDAW obligates States to take all appropriate measures, including legislation to suppress trafficking and exploitation of women. Similarly, in Articles 19 and 34, the CRC obligates States Parties to protect children from sexual exploitation and sexual abuse.

## 11. The Right to Access Sexual and Reproductive Health Education and Family Planning Information

To effectively and freely make decisions regarding family size and reproductive health, individuals must have access to relevant information and education.

CEDAW requires States Parties to provide women and girls with educational information that will ensure the wellbeing of families, including information and advice on family planning. 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.

In *A.S. vs. Hungary,* the CEDAW Committee found that Hungary violated Article 10 where women did not have "information about contraceptive measures and their use."[92] The Committee concluded that A.S. could not make informed decisions about safe and reliable contraceptive use without access to adequate information.

Under the CRPWD, persons with disabilities have the same rights to family planning, reproductive, and sexual information. Article 23 of the CRPWD demands:

> "States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that the rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided."

92 *A.S. vs. Hungary,* Committee on the Elimination of Discrimination Against Women, CEDAW/C/36/D/4/2004 (2006).

A woman cannot freely choose a method of contraception if she is unaware of her options. Women need to understand the risks and implications of anemia to ensure healthy pregnancies. A woman cannot control her reproductive autonomy if she does now know of abortion providers in her community. Reproductive rights cannot be accessed without adequate education and information.

### 12. The Right to Enjoy the Benefits of Scientific Progress

Finally, reproductive rights include the right to enjoy the benefits of scientific progress. Article 7 of the ICCPR states, "No one shall be subjected without his (or her) free consent to medical or scientific experimentation." In reproductive rights, this would include forced sterilization, forced Cesarean-Section delivery, non-consensual clinical trials or drug testing, medically unnecessary procedures, and forced abortion. This right may also have implications for India's burgeoning surrogacy and in vitro fertilization industry.

## Looking Ahead

Since the first edition of *Claiming Dignity*, HRLN has made significant strides in reproductive rights litigation. Public Interest Litigation (PIL) on maternal mortality has been filed in nearly every state. Activists have continued to file petitions across the reproductive rights spectrum on issues ranging from access to safe abortion to coercive sterilization. Courts have issued interim orders and bold proclamations about women's rights to health, to safe pregnancy, and to life.

This progress inspires HRLN to push for stronger judgments that address gender discrimination, violations of cruel, inhuman, and degrading treatment, and meaningful accountability standards. We hope advocates and activists will use this book as an effective tool in litigating and advocating on reproductive rights issues.

## How to use this book:

The case law section of this book includes information on reproductive rights litigation from across India. In many cases, the Supreme Court or State High Court has issued its final judgment and disposed of the matter. We have also included pending matters to provide a fuller spectrum of reproductive rights litigation.

For each matter presented, we have included:

- The case name and citation (including the Court, type of case, case number, and year of filing),

- A brief synopsis,
- The facts of the case,
- The relevant law cited in the petition or final judgment,
- The outcome, and
- An abridged version of the Court's orders and/or judgments.

We hope that advocates and activists will find this material helpful in their struggle to ensure reproductive rights and basic dignity for women throughout in India.

# Abortion

## Chandigarh Administration v. Nemo, High Court of Punjab & Haryana at Chandigarh C.W.P. 8760/2009, Supreme Court Appeal 5845/2009

### Synopsis

In this case, the Supreme Court of India affirmed the right of mentally retarded women to control their reproductive rights. The Chandigarh Administration argued that it was not in the respondent's interest to continue the pregnancy as it resulted from rape, and that the victim did not understand the significance of pregnancy and childcare. On appeal, the Supreme Court decided that language in the Medical Termination of Pregnancy Act and the respondent's personal autonomy to decide whether to continue her pregnancy must take precedence over eventual burdens that the State could face in assisting her, as her mental disability was mild and did not affect her decisional capacity.

### Facts

The Chandigarh Administration sought instructions from the High Court of Punjab & Haryana about whether to terminate the pregnancy of a woman with mild to moderate mental retardation. The woman was an orphan, aged 19-20 years old, who became pregnant after a sexual assault perpetrated by guards of the government-run care home where she had previously lived.

### Relevant Law

*Constitution*: Articles 14 (right to equal protection) & 21 (right to a dignified life)

*Statutes & Schemes*: Medical Termination of Pregnancy Act, 1971

*International Law*: United Nations Declaration on the Rights of Mentally Retarded Persons, 1971 [G.A. Res. 2856 (XXVI) of 20 December, 1971]

### Outcome

*In the High Court*

Under the Medical Termination of Pregnancy Act, 1971 (MTP Act), a pregnancy can

only be terminated before the 20th week; in cases where the woman is below the age of majority or suffers from mental illness, a guardian can decide whether to terminate the pregnancy on the woman's behalf. Although the MTP Act specifically distinguishes mental illness from mental retardation or disability, and does not require a guardian for mentally retarded women, the High Court decided that refusing to appoint a guardian to represent the best interests of a woman with mental retardation would frustrate the Act's purpose of protecting the health of pregnant women.

The Court appointed an Expert Body to examine the victim and determine whether she had decisional capacity and, if so, what her wishes were with respect to terminating her pregnancy. According to the experts, the woman did have some limited capacity to understand her situation. Although she could do some basic chores and she knew that she was pregnant, she did not understand how she had become pregnant or the nature and responsibilities associated with childbirth and childcare. It was also determined that her poor long-term memory and dependence on rote memorization made her susceptible to suggestion, meaning she may have expressed a desire to have the child without genuinely understanding and agreeing to the concept.

Nevertheless, the Expert Body could not agree that the pregnancy should be terminated, as the woman seemed to have sufficient decisional capacity. However, given the woman's inability to fully comprehend her situation and the difficulties childbirth and childcare would impose on her, the Court determined that her interests would be best served by terminating the pregnancy, avoiding the continued mental anguish of the sexual assault, and relieving her of childcare responsibilities she could neither appreciate nor handle on her own.

*In the Supreme Court*

On appeal, the Supreme Court stayed the planned abortion. The Court expressed concern that, in spite of the fact that the Expert Body had not recommended it, the High Court nevertheless determined it was in the woman's best interest to terminate her pregnancy. In addition to highlighting domestic and international law protecting the rights and autonomy of people with mental retardation, the Court emphasized that sterilizations and other violations of people with mental disabilities in the recent past could not be ignored.

In light of the plain language of the MTP Act, as well as international law protecting the rights of mentally disabled individuals, the Court found that a guardian could not be appointed for the victim in this case. As such, her consent to the termination of the pregnancy was required. The Court ordered the State to ensure that the best medical

facilities were available to care for the woman in pregnancy and childbirth, and that all needed care and welfare aid be given after the child's birth.

## Orders

*High Court of Punjab and Haryana, Chandigarh*

### June 9th, 2009

The Chandigarh Administration has filed this writ petition … seeking permission for medical termination of the pregnancy of a mentally retarded girl…who was previously an inmate of the Nari Niketan, Sector 26, Chandigarh and has presently been shifted to Ashreya – a Home for the mentally challenged…. The medical termination of pregnancy of the victim has been sought on the strength of the medical opinion dated 27.5.2009 given by the Multidisciplinary Medical Board of the Government Medical College and Hospital, Sector 32, Chandigarh.

[2] The following facts would unfold the pathetic story of physical and mental abuse of a hapless girl in a Government-run Institute:-

[a] The victim, an orphan, was under the guardianship of New Delhi Missionary of Charity till 28th December, 1998. ... As the girl was mentally retarded, the New Delhi Missionary of Charity put her under the guardianship [of]… the Government Institute for Mentally Retarded Children, Sector 32, Chandigarh. While studying there, she ran away from the said Institute on 20th March, 2005. She was later on traced by the police and brought to the Nari Niketan, Sector 26, Chandigarh. …

[b] After the victim was shifted to Chandigarh, one Roshan Ara Khatun, wife of Mohammad Farukh, claimed her custody under the mistaken belief that she was her lost daughter Reshma but soon thereafter "admitted" her mistake and declined to keep her.

According to Roshan Ara Khatun, she was convinced that the victim was not her daughter for the reason that there was no mark of a cut on the waist of her daughter Reshma which is noticeable on the waist of the victim. Consequently, the victim was brought back to the Nari Niketan under the orders of the Sub Divisional Magistrate, who had earlier, even without proper verification, handed-over the custody of the victim to Roshan Ara Khatun.

[c] The petitioner claims that on 16th May, 2009, a Medical Social Worker and a Staff Nurse working in Ashreya observed that the victim had a feeling of nausea and complained of pain in lower abdomen. The victim also disclosed to them that she had missed her last two menstrual periods. The Medical Social Worker and the Staff Nurse, on their own, conducted a pregnancy test from the victim's urine and found it to be positive. …[C]linical examination of the victim, found out that she was 8-10 weeks' pregnant. ... Due to the increasing abdominal pain, the victim was admitted to the Gynae Ward of the Hospital and thereafter, an ossification test is said to have been conducted on 20th May, 2009, which set her bone age to be between 19-20 years.

[d] The pregnancy of an unwed mentally retarded girl having been confirmed, the authorities swang into motion and informed the Chandigarh Police on 18th May, 2009 itself, which led to the registration of FIR No. 155 dated 18th May, 2009 under Section 376 and 120-B IPC at the Police Station, Sector 26, Chandigarh. The FIR does mention the name of the principal accused as well as the abettor of the heinous offence. The case is stated to be still under investigation by a Special Investigation Team [SIT].

[e] The Director-Principal of the Government Medical College and Hospital, Sector 32, Chandigarh thereafter constituted a Three Member Medical Board…to evaluate the mental status of the victim, who in turn opined that she is in the category of "mild mental retardation". ...

[f] The aforesaid Board submitted its opinion on 27th May, 2009, recommending medical termination of the pregnancy of the victim, inter-alia, for the following reasons:-

"1 …….

2. There is no doubt that this pregnancy is an outcome of the rape. In spite of being upset over mentally challenged, she has earlier communicated to her examiners about being upset over this incident and has lost interest in certain activities which were enjoyable earlier...

3. She has undergone a major spinal surgery during her childhood as she was not able to walk. Although she is not able to elaborate the details further. The cause of mental retardation in presence of bony abnormalities can have a genetic basis and can be inherited by the baby.

4. Continuation of pregnancy in this case can be associated with certain complications considering her age, mental status and previous surgery. There

are increased chances of abortions, anaemia, hypertension, prematurity, low birth weight babies, foetal distress and more chances of operative delivery including anaesthetic complications. Babies who are premature and low birth weight may have organs that are not fully developed.
This can lead to breathing problems, such as respiratory distress syndrome, bleeding in the brain, vision loss and serious intestinal problems.

5. Being mildly mentally retarded, she is unable to look after herself and can not fend for herself if left to her own devices. She was aware that there is a child inside her, although she had absolutely no idea how it came to be there. She cannot mother a child. Motherhood is not only holding the child but it is a complex relationship which is beyond her capability and comprehension.

6. Child of a rape victim who doesn't have family support can have social and emotional problems which can jeopardise his complete physical, mental and social well being later.
… Considering all the above points, the board is of the opinion that she will not be able to cope with the continuation of pregnancy which in this case is detrimental for her and the child's health, and so recommends medical termination of pregnancy [MTP]."

[3]. The Parliament has enacted the Medical Termination of Pregnancy Act, 1971 [in short 'the 1971 Act'] with an awed object to liberalise and permit termination of pregnancy wherever necessary, [i] to protect the mother's health, strength and/or life; [ii] on humanitarian grounds such as when pregnancy arises from a sex crime like rape or intercourse with a lunatic [now replaced by the expression 'mentally ill'] woman etc.; and [iii] on eugenic grounds, namely, where there is a substantial risk, i.e., the child, if born, would suffer from deformities and diseases. … Section 5 of the Act is an exception to Section 3 and 4 of the Act. The aforesaid provisions read as follows:-

"2. Definition:- In this Act, unless the context otherwise requires,-

[a] "guardian" means a person having the care of the person of a minor or a mentally ill person.

[b] "mentally ill person" means a person who is in need for treatment by reason of any mental disorder other than mental retardation.
[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 1.- 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 then pregnant woman.

[8]. The petitioner Administration could have possibly resolved the issue[s] raised herein through its own administrative mechanism, namely, by…appoint[ing] a guardian of the person with disability and who [the guardian so appointed], in turn, can act in the best interests of the disabled person, including giving consent for medical termination of the pregnancy in accordance with the provisions of the 1971 Act. The Chandigarh Administration instead opted for approaching this Court to issue appropriate directions as…the petitioner is unwilling to become a Judge in its own cause.

…

[11].In our considered view and owing to the very nature of the relief sought by the petitioner, the principal and moot point which requires determination by this Court is as to whether the pregnancy of the victim is liable to be terminated and if so, who shall be the competent person to give consent for such termination? In other words, should the consent of the victim be considered mandatory to terminate her pregnancy or, this Court, in exercise of its parens-patriae jurisdiction, can assign such consent by issuing appropriate directions? ...

[12]. ... Sub-Section [2] of Section 3 [of the 1971 Act] authorises the registered medical practitioner[s] to terminate a pregnancy on formation of an opinion in good faith that continuation of the pregnancy would risk the life of the pregnant woman or cause grave injury to her physical or mental health, after taking into account her actual or reasonable foreseeable environment, or if 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.

…

Sub-Section [4] of Section 3, however, obligates that the pregnancy can not be terminated except with the consent of the pregnant woman or of her guardian if the pregnant woman has not attained the age of 18 years or is a mentally ill person. Section 5 of the Act enables termination of the pregnancy if it is immediately necessary "to save the life of the pregnant woman". On a plain reading of the statute and given the literal meaning to its provisions, it can be plausibly inferred that if the pregnant woman is above 18 years of age, the consent of the guardian would be necessitated only if she is a mentally ill person. It would necessarily imply that if the pregnant woman is above

18 years of age and is a mental retardee only, she alone would be competent to accord consent for termination of her pregnancy as mandated by sub-section [4][b] of Section 3 of the Act.

[13]. Mr. Anupam Gupta, learned Senior Standing Counsel for the petitioner, however, has taken us not only to various provisions of different statutes but also to the Medical & Legal Texts and the opinions expressed by renowned subject specialists and experts, to contend that the literal meaning, if given, would render the Act unworkable and senseless besides frustrating the legislative intentment and objects sought to be achieved through the later legislations…. He urged that there is an inherent fallacy in understanding Section 3 of the 1971 Act to construe that howsoever severe may the degree of mental retardation be, the consent of the retardee alone would be required, whereas in the case of mental illness, howsoever mild it may be, that the consent can be accorded by a guardian only. …

[15]. Shri Gupta made a passionate reference to the medical reports/opinions on record and urged that having regard to the deficiencies in the areas of self-help grooming and socialisation and the fact that she is unable to look after herself and can not fend for herself if left to her own devices, coupled with the IQ level of the victim stated to be that of a nine years old, especially owing to the major spinal surgery undergone by the victim during her childhood and possibility of bony abnormalities to be genetically inherited by the baby, this Constitutional Court should come to the rescue of the victim and invoke its parens-patriae jurisdiction by granting permission to terminate the pregnancy, which is otherwise also a cause of anguish having been caused by a diabolic act of rape. …

[17]. Emphasis has also been laid on 25 principles adopted by the General Assembly of the United Nations for the protection of persons with mental illness and for improvement of mental healthcare, with a special reference to the following clauses:-

"Principal 1: Fundamental freedoms and basic rights:-

6. Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. …"

"Principal 11. Consent to treatment.

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle.

2. Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:-
   [a] the diagnostic assessment;
   [b] the purpose, method, likely duration and expected benefit of the proposed treatment;
   [c] alternative modes of treatment, including those less intrusive;
   [d] possible pain or discomfort, risks and side-effects of the proposed treatment.

8. Except as provided in paragraphs 12, 13 and 15 of the present principle, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorised by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose".

[18]. We may summarise and say that the Medico Legal Literature has been relied upon as an external aid for interpreting Section 3[3] of 1971 Act to mean that in the case of a mentally retarded pregnant woman also the consent of her guardian is essential, as according to Shri Gupta, the persons classified as 'mentally retarded' have more deficits in social and cognitive functioning and have very limited behaviourial or decision making abilities including the tendency to go alone or acquiescence in ambiguous situations. The aims and objects coupled with various provisions of the 1995 and 1999 Acts have also been relied upon to urge that in the wider category of 'disabled persons', the persons suffering from 'mental retardation' or 'mental illness' - both have been included and treated at par, especially in the context of appointment of a guardian under Section 14 of the 1999 Act.

[19]. While pressing into aid the doctrine of parens-patriae…Shri Gupta urged that while appointing a guardian the Courts in India have consistently exercised the parens-patriae jurisdiction and, therefore, in the peculiar facts and circumstances of this case, where the victim is in the custody of the petitioner State and the decision for medical termination of her pregnancy is also required to be taken by the petitioner itself, it is a fit case for this Court to exercise the parens-patriae jurisdiction and act as guardian of the victim in her best interest.

…

[21]. Per-contra, Shri R.S.Cheema, learned Senior Counsel and the amicus-curiae well assisted by Miss Tanu Bedi, Advocate, urged strenuously that there is no ambiguity in the provisions of the 1971 Act, rather the expression "mentally ill person" has been added recently by Act No. 64 of 2002 in substitution of the expression "lunatic" and the legislation was fully conscious and informed of the consequences of excluding mentally retarded persons from the category of 'mentally ill persons'.

...

According to the learned amicus-curiae, there is no legislative omission while excluding the retardees from the category of mentally ill persons as retardation is only a mental condition distinct from mental disease. Shri Cheema highlighted the medical opinion which is suggestive of the victim's self sustenance; her perception and thinking process being normal; her orientation to time, place and person; her immediate, recent and remote memory being intact and the fact that she is adept in activities of daily living. ... He lambasted the petitioner for seeking termination of the pregnancy for the sake of convenience and not for the reason of necessity. ... In no uncertain terms, argued Shri Cheema, the consent of the victim shall be a condition precedent before medical termination of her pregnancy. Besides making a pointed reference to the Declaration on the Rights of Mentally Retarded Persons proclaimed by the General Assembly Resolution dated 20th December, 1971, re-affirming that the mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings, Shri Cheema has also relied upon…universal recognition of the Fundamental Rights of the mentally retarded persons, recent theory of mixing them in the main social stream instead of barricading at a secluded place, that the legislative transformation has also taken place whereby purposefully and knowingly, the competence to give consent for medical termination of a pregnancy in the cases of mentally ill pregnant woman on one hand and mentally retarded pregnant woman on the other hand, has now been distinguished.

....

[23]. The literature including the opinions and articles relied upon by the learned amicus-curiae, does suggest that the individuals with the mental retardation have developmental delays in learning and processing information, yet nearly 85% of them are able to live successfully in the community. People with mild mental retardation account for about 85%; they more or less develop normal language abilities and social behaviour during the pre-school years and their learning disability may never be formally identified; most of them can lead their lives independently in ordinary surroundings, though they may need help in coping with family responsibilities, housing and employment or when under unusual stress.

…

[26]. We now proceed to examine the medical evidence on record recommending termination of pregnancy of the victim, the approval whereof is sought from this Court. ... The Board met the victim, spent some time with her and submitted an evaluation report …

[27]. Having pondered over the rival contentions revolving aground the moot point for determination and on a plain reading and a literal meaning of sub-section [4] of Section 3 of the 1971 Act, it appears that the written consent of a guardian for medical termination of pregnancy is needed if [i] the pregnant woman has not attained the age of 18 years; or [ii] she is a mentally ill person. Since the expression "mentally ill person" does not include a person who is in need of treatment by reason of mental retardation, the purposive construction of sub-section [4][a] of Section 3 of the 1971 Act can not be stretched to include "mentally retarded persons" also. Similarly, sub-Section [4][b] does not intend to exclude from its ambit the mentally retarded pregnant woman. We say so for the reason that when the words in a Statute are not ambiguous and are capable of bearing one construction only…and the provision has to be interpreted as such regardless of its consequences. Any interpretation which may amount to re-writing of the statute, falls outside the jurisdictional scope of this Court. It further appears to us that the amendment introduced vide Act No. 64 of 2002 is a progressive legislation based upon universally accepted theory that though mental retardedness may be incurable, yet a retardee has a fundamental human right to live and enjoy the main social stream. It means that ordinarily a mentally retarded pregnant woman who is more than 18 years of age has a right of self determination regarding continuation or otherwise of her pregnancy.

[28] The literal interpretation as given above, however, completely falls short of achieving the legislative object of not only the 1971 Act, it may also tinker with the legislative object of the 1999 Act as well as the UN Declaration on the rights of the mentally retarded persons. We say so for the reason that in the context of termination of pregnancy being a penal offence prior to the 1971 Act came into force and one of the objects of the Act being permitting the termination of pregnancy on humanitarian grounds when it is caused by a sex crime like rape … any interpretation should lean towards liberalizing medical termination of pregnancy.

[29]. We are unhesitatingly of the view that such like cases can not be decided on the solitary strength of interpretation of legal provisions. Besides being vested with plenary and inherent jurisdiction to act as a custodian of the fundamental and human rights of the citizens, a writ Court while exercising parens-patriae jurisdiction owes a bounden duty to act in the best interest of the guardee, keeping in view his/her

care, protection, health, education, intellectual development, comforts, contentment and congenial environment, along with moral and ethical values, ….

[30]. While adopting a holistic approach in interpreting the 1971 Act, we have also kept in view the fact that the 1995 Act though defines "mental illness" and "mental retardation" separately and distinctly, nevertheless both have been clubbed together for the purposes of State's endeavour for their education, employment, affirmative actions and non-discrimination. … What is, however, common in the three legislations is the welfare of the 'mentally ill' as well as the 'mentally retarded' persons in order to secure their social rehabilitation through legislative means. It is in the context of achieving the legislative objects that the 1999 Act visualises the need of appointment of a guardian that may arise even in the case of a 'mentally retarded person'. In our view, the exclusion of mentally retarded persons from the category of mentally ill persons under the 1971 Act is not absolute in the sense that irrespective of the foreseeable environment in which such mentally retardee is living or the degree and condition of mental retardedness, the Court even while exercising its parens-patriae jurisdiction can not appoint a guardian to determine as to whether or not the continuance of the pregnancy of a mentally retarded major pregnant woman involves risk to her life or can cause grave injury to her physical or mental health.

[31]. The Courts can not be oblivious of the fact that ours is a country inflicted with imbalanced male-female sex-ratio; marred by female foeticide; ashamed of a vast majority of abandoned girls in orphanages; clouded with social evils like dowry; poor literacy rate amongst girls, with alarming increase in dowry deaths and, therefore, the freedom of consent given to a mentally retarded major pregnant woman by virtue of sub-section [4] of Section 3 of the 1971 Act, has to be taken as susceptible and can not be accepted on its face value by a Court while exercising its parens-patriae jurisdiction. Howsoever laudable the legislative object may be, the realities of life including the fact that the "consent" of a person with best of prudence, can be secured by dubious means of undue influence, fraud, misrepresentation etc. etc., we decline to accept the omnibus interpretation of sub-section [4] of Section 3 of the 1971 Act that in the case of a mentally retarded major pregnant woman, the medical termination of her pregnancy shall always depend upon her own decision.

[32]. The system and the society both have been very unfair and cruel to the victim in this case. The material on record does suggest that her bony deformity and the consequential life-long disability might have been the factor which made her parents so cruel that they threw her out to survive all by herself in an unknown and unkind

world. ... The casual approach and criminal negligence of the authorities is writ large by the fact that the victim was sent with Roshan Ara Khatun even without verifying the bonafide of the claimant or an iota of evidence to establish her relationship with the victim. The fact that the victim is alleged to have been ravished by none else than the guard of the institute, is enough for us to form a firm opinion that the victim has been treated like a subject, traumatised to the highest degree and has been made to witness all possible miseries. We are at pains to observe that the mechanical approach and callousness with which the welfare institutions are being apparently run, the victim has been deprived of an environment which could have been conducive to her mental growth, social behaviour and an over-all personality development.

…

[34]. We accordingly hold that notwithstanding the plain and literal meaning of sub-section [4] of Section 3 of the 1971 Act, every Court while exercising its parens-patriae jurisdiction is competent to act or appoint guardian ad-litem of a mentally retarded major pregnant woman for the purpose of deciding the retention or termination of her pregnancy in her best interest, though depending upon the individual facts and circumstances of each case. Such guardian may consult or seek consent of the pregnant woman concerned for the purpose of formation of his final decision as to whether or not the pregnancy be medically terminated.

[35]. In the light of what has been held above, and taking into consideration the medical opinion/evidence on record, which we have no reason whatsoever to doubt or disbelieve, and taking notice of the predicament of the petitioner – State and for the absolute satisfaction of this Court in its capacity as a parens-patriae, we are of the considered view that the following vital issues need to be answered by an Expert Body, who should be free from the administrative control and/or influence of the petitioner – the Chandigarh Administration:-

[i] the mental condition of the retardee;

…

[iv] her capability to acknowledge the present and consequences of her own future and that of the child she is bearing;

[v] her mental and physical capacity to bear and raise a child;

[vi] her perception about bringing up a child and the role of an ideal mother;

[vii] does she believe that she has been impregnated through unvolunteered sex?

[viii] is she upset and/or anguished on account of the pregnancy alleged to have been caused by way of rape/un-willing sex?

[viii] is there any risk of injury to the physical or mental health of the victim on account of her present foreseeable environment?

[ix] is there any possibility of exerting undue influence through any means on the decision-making capability of the victim?

[x] Do the over-all surroundings provide reasonable space to the victim to indulge in independent thinking process and take firm decisions on the issues vital to her life prospects?

[xi] What is the possible nature of the major spinal surgery alleged to have been undergone by the victim during her childhood?

Does it directly or indirectly relate to the bony abnormalities of the victim? Can such abnormalities have a genetic basis to be inherited by the baby

[xii] Is there a genuine possibility of certain complications like chances of abortion, anaemia, hyper-tension, prematurity, low birth weight baby, foetal distress, including chances of anaesthetic complications, if the victim in the present case, is permitted to carry on the pregnancy?

[xiii] What can be the most prudent course to be followed in the best interest of the victim?

…

[37]. We direct the petitioner – Chandigarh Administration to approach the Director, PGIMER, Chandigarh to make available the above stated team of Experts…. The petitioner – Chandigarh Administration is further directed to produce the victim before the Expert Body at a place to be chosen by the latter and for as much time as may be required by the Expert Body. .... The Expert Body shall submit its opinion on the issues illustrated above but nothing precludes the Expert Body from framing any other additional issue[s] as may be deemed appropriate and give its categoric opinion in relation thereto within ten days from today. ...

[38]. If the Expert Body forms a bona-fide opinion that the pregnancy needs to be medically terminated in the best interest of the victim, we in exercise of our parens-patriae jurisdiction, direct the petitioner Administration to admit the victim in the Government Medical College and Hospital, Sector 32, Chandigarh, constitute a team of Medical Experts…who shall then terminate the pregnancy of the victim forthwith and without any delay as soon as the report of the Expert Body is received. The Authorities of the above mentioned College and Hospital are directed to ensure best of the post-operational medical services to the victim. We further direct that, in such an eventuality, the foetus shall be preserved for the DNA and other scientific tests, especially for the purposes of the criminal case pending investigation. ...

[39]. We clarify that if despite acknowledging the present and future implications/ consequences, the victim strongly opposes the termination of her pregnancy, in that event the report of the Expert Body along with the expression of views by the victim shall be placed before us before July 01, 2009 for determining as to whether or not the pregnancy of the victim should be medically terminated.

[40]. Some of the learned counsel have accused and rightly so the manner in which the Institutions like Nari Niketan or Ashreya are being run. The fact that a hapless mentally retarded inmate of one of the petitioner's Institutes has been allegedly raped by none else than one of the guards of the Institute, tells the tale of criminal and administrative negligence, callousness, and an indifferent attitude of those who are at the helm of affairs in these Institutions. ... If the allegations are found to be true, what more would be needed to be an eye opener for the high eclons of the Administration to introspect and carry out sweeping administrative reforms towards the objects sought to be achieved. We, therefore, deem it appropriate to dispose of this writ petition with the following additional directions:-

[a] there shall be a notified Medical Board headed by the Director, Health Services, UT, Chandigarh and should also consist of all possible subject specialists, necessarily including a Gynaecologist; a Skin Specialist and a Counsellor etc. as Members, who shall be required to visit, fortnightly and examine each and every inmate of the Nari Niketan, Ashreya or any other Government run/aided institution of this kind. The Medical Board shall submit its periodical report to the Secretary, Department of Health, UT Administration, who shall be required to satisfy himself regarding the adequate medical aid and assistance to the inmates;

[b] the periodical examination of the inmates of the Nari Niketan, Ashreya or any other Institution shall necessarily include their examination as to whether or not the inmate has been subjected to any sexual or digital abuse;

[c] in case the medical Board finds any inmate to be a victim in terms of the direction [b] above, the matter shall be reported to the local police forthwith and further legal action, as per the law, shall follow;

[i] we also direct the petitioner Administration not to keep/employ male employees for the internal functioning of the Institutions unless all the inmates are males only. The petitioner Administration shall also explore the feasibility of employing retired Lady Police Officers/Officials or in the alternate Ex-Army Personnel for the outer security purposes of such Institutions;

…

**July 17, 2009**

…

[3]. …[W]e have held vide our order dated 9th June, 2009 that literal interpretation of Section 3(4) of the Medical Termination of Pregnancy Act, 1971 (in short 1971 Act) cannot impinge upon the constitutional powers of this Court, especially its *parens-patriae* jurisdiction to be exercised in the best interest of the *guardee*. We accordingly declined to accept that "*in the case of a mentally retarded major pregnant woman, the medical termination of her pregnancy shall always depend upon her own decision*".

[4]. With a view to be inerrant about the mental and physical state of the victim, we decided to obtain a second medical opinion from an Expert Body....

…

[8]. It would be appropriate, at this stage, to reproduce the issues raised by us in our order dated 9th June, 2009 and the response thereto by the Expert Body in the following tabulated form:-

[i] the mental condition of the retardee

She suffers from mild to moderate mental retardation.

[ii] her mental and physical condition and ability for self sustenance
A case of Mild to moderate Mental Retardation, Pregnant : Single live foetus corresponding to 13 weeks 3 days +/- 2 weeks, Postoperative scars for spinal surgery, HbsAG positive. Her mental status affects her ability for independent socio-occupational functioning and self-sustenance. She would need supervision and assistance.

[iii] her understanding about the distinction between the child born out of and outside the wedlock as well as the social connotations attached thereto.
As per her mental status, she is incapable of making the distinctions between a child born before or after marriage or outside the wedlock and is unable to understand the social connotations attached thereto.

[iv] her capability to acknowledge the present and consequences of her own future and that of the child she is bearing.
She knows that she is bearing a child and is keen to have one. However, she is unable to appreciate and understand the consequences of her own future and that of the child she is bearing.

[v] her mental and physical capacity to bear and raise a child.

She is a young primigravida with abnormalities of gait and spinal deformity and Hepatitis B surface antigen positive status. However, she has adequate physical capacity to bear and raise a child. She is a case of mild to moderate mental retardation which often limits the mental capacity to bear and raise a child in the absence of adequate social support and supervision.

[vi] her perception about bringing up a child and the role of an ideal mother.

She has grossly limited perception about bringing up a child and the role of an ideal mother.

[vii] does she believe that she has been impregnated through un volunteered sex?

She has a limited understanding of the sexual act and relationship, and even the concept of getting pregnant. She did not volunteer for sex and did not like the sexual act.

[viii] is she upset and/or anguished on account of the pregnancy alleged to have been caused by way of rape/un-willing sex?

She has no particular emotions on account of the pregnancy alleged to have been caused by way of rape/un-willing sex. She is happy with the idea that she has a baby inside her and looks forward to seeing the same.

[ix] is there any risk of injury to the physical or mental health of the victim on account of her present foreseeable environment?

Her internal environment of pregnancy does not pose any particular risk of injury to the physical health of the victim. Her mental health can be further affected by the stress of bearing and raising a child. Her external environment in terms of her place of stay and the support available thereof is difficult to comment because of our lack of familiarity with the same. She definitely needs a congenial and supportive environment for her as well as for the safety of the pregnancy.

[x] is there any possibility of exerting undue influence through any means on the decision making capability of the victim?

Her mental state indicates high suggestibility because of her reliance on rote memory and imitative behaviour for learning. Being highly suggestible her decision making can be easily influenced.

[xi] Do the over-all surroundings provide reasonable space to the victim to indulge in independent thinking process and take firm decisions on the issues vital to her life prospects?

We are not familiar with her over-all surroundings, hence unable to comment.

[xii] What is the possible nature of the major spinal surgery alleged to have been undergone by the victim during her childhood? Does it directly or indirectly relate to the bony abnormalities of the victim? Can such abnormalities have a genetic basis to be inherited by the baby?

As per the neurosurgeon, spinal surgery during childhood could have been due to neural tube defect or spinal cord tumour. This could have been confirmed by MRI tests, but the same could not be carried through as those were considered to be potentially hazardous for the foetus. There is no history/records available for the spinal surgery, hence, the safety profile issues relevant for the patient undergoing MRI like the possibility of use of any metal screws to fix the spine wherein MRI can be hazardous can not be definitely commented upon in this case. The neural tube defect in the patient can lead to an increased chance of neural tube defect in the baby. However, these defects can be detected by blood tests of the mother and ultrasound. Presence of neural tube defect in the parent is not an indication for termination of pregnancy. It is not possible to comment on the inheritance of spinal cord tumours without knowing the exact nature of the tumour.

[xiii] Is there a genuine possibility of certain complications like chances of abortion, anaemia, hyper-tension, prematurity, low birth weight baby, foetal distress, including chances of anaesthetic complications, if the victim in the present case, is permitted to carry on the pregnancy?

The possibility of complications like abortion, hypertension, prematurity, low birth weight baby and foetal distress are similar to any pregnancy in a woman of this age group.

Due to the spinal abnormality and gait defect she has a higher chance of operative delivery and associated anaesthetic complications. Spinal and gait abnormalities are not an indication for termination of pregnancy. Pregnancy in women with Hepatitis B surface antigen positive status is usually uneventful. The prenatal transmission from mother to infant can be prevented by giving immunoprophylaxis to the neonate.

Acute or chronic Hepatitis B infection during pregnancy is not an indication for termination of pregnancy.

[xiv] What can be the most prudent course to be followed in the best interest of the victim?

Her physical status poses no major physical contraindications to continue the pregnancy. The health of foetus can be monitored for any major congenital

defects. Her mental state indicates limited mental capacity [intellectual, social adaptive and emotional capacity] to bear and raise the child. Social support and care for both the mother and the child is another crucial component. Therefore, any decision that is taken keeping her best interests as well as her unborn child has to be based on the holistic assessment of physical, psychological and social parameters.

[9]. Though vide para 38 of our order dated 9th June, 2009, the Expert Body was explicitly authorized to go ahead with the medical termination of the pregnancy of the victim upon its satisfaction, nevertheless, the Expert Body has expressed its hesitance to take a final decision and has submitted its report[s]. The learned Judicial Officer, while compiling the opinion of the subject experts, has also loaded the report with her own opinion against termination of the pregnancy.

…

[12]. The matter, however, did not end there. The compiled report and the response given by the Expert Body to some of the issues formed by us suggest that the victim "wants to keep the child" and that "she likes children" and does not "want to be deprived of the child". ... Learned counsel for the petitioner, while highlighting the mental incapacities of the victim as reported by the subject-experts, urged that this Court should avert the tragedy of a "child" bearing another 'child' and feverishly argued that the victim being totally unable to understand the sexual behaviour or social connotations of a child born 'out' of and 'outside' the wedlock, is mentally incapable to give "consent", what to talk of an informed consent. According to him, the so-called consent given by the victim for retention of her pregnancy is no consent, either in law or on facts.

[13]. *Per-contra*, and propounding the theory of pro-life and pro-choice, the learned *amicus curiae* reminded us that even as per the report of Dr. Avasthi, the victim is a mentally retarded person (and not a mentally ill person) and she being major, her pregnancy cannot be terminated without her consent, as mandated by Section 3 (4) of the 1971 Act and since the victim has expressed her desire to keep the child, this Court is now left with a limited choice….

[14]. We have given our thoughtful consideration to the rival contentions raised at the bar in a continuous hearing for over ten days; have also gone through the relevant parts of the referred books, literature and articles.... Vide our previous order dated 9th June, 2009 we have already held, though with a caveat, that Section 3[4] of the 1971 Act can not be interpreted in abstract to mean that in the case of a mentally retarded major pregnant woman, her own consent alone shall determine the fate

of the pregnancy. We say so for the reason that the social environ as well as the attending circumstances of the said mentally retarded pregnant woman shall guide as to what extent and how far the State or the Court, would be required to step forward to exercise their *parens-patriae* jurisdiction to decide as to whether or not she is fully capable to give consent after acknowledging the consequential implications. In other words, the guardian *ad-litem* shall have to ascertain that the "consent" is free from any type of undue influence, distress and is realistic in the sense that the mental capacity of the person giving consent is beyond doubt.

…

[16]. Some of the following factors are undeniably of paramount consideration on the child bearing capacity of any major woman including the victim:-

…

## [ii] THE MENTAL CAPACITY OF THE MOTHER:-

[18]. The victim is admittedly a mentally retarded person. While she was categorized as a "mild" mental retardee by the first set of experts, Prof. Awasthi of PGIMER has categorized her between "mild to moderate" mental retardee. She has no idea as to how conception takes place, the development of pregnancy or even the duration of pregnancy. She does not know as to how the child inside her will come into the real world. She does not know the child rearing or how to provide succour and sustenance to the child. ... Most of the mental operations of the victim are guided by rote memory and imitative behaviour. Prof. Awasthi has opined that since much of the adaptation by the victim is a consequence of imitative behaviour and rote memory, **there is high propensity for suggestibility.** ... **There is poor understanding** of life phase demands and expectations in the areas of social reactions, social roles including marriage and child bearing roles, understanding of cultural traditions and her capacity to cope with those; though she is properly groomed and displays adequate skills for basic self-care but practical and domestic skills are rudimentary due to which she has **impaired social and test judgment of significant emotional immaturity**. …

...

[19]. We may mention here that according to the Experts as well as the Social Worker, who had an occasion to interact with her, the victim has absolutely no knowledge as to how a woman becomes pregnant and obviously has no idea about her own pregnancy. For her "a child" is a "toy" with whom she likes to play and, therefore, she wants the child inside her to come outside so that she can play with him. Prof. Awasthi has found that the victim has no understanding of a mother-child relationship as according to her the child in her womb is her "Bhaiya" [brother] like any other male to whom she probably addresses as 'Bhaiya'.

## [IV] FINANCIAL CONDITIONS:-

[21]. Financial conditions has an impact on the capacity to bear and raise a child as notwithstanding the loud claims of various welfare Schemes made by the States, a vast majority of children belonging to the poor sections of society are mal-nutritioned and even their bare necessities are seldom fulfilled. The victim herein is an illiterate mentally retarded young girl who does not possess any occupational skills. ... Would she ever be able to work and earn independently for self-sustenance is a highly debatable issue.

## [v] *SOCIAL OR FAMILY SUPPORT:-*

[22]. There can indeed be no doubt that an intellectually impaired pregnant woman, suffering from other disadvantageous conditions illustrated above, can legitimately discharge parenting responsibilities given the social or family support needed during those anxious times. ... The absence or lack of family support, to a large extent can be adequately met with by responsible, caring and vigilant social Institutions or social groups. Our desperate search for an Institution where the victim or the future child could be emotionally compensated, socially protected and groomed well to survive on selfhelp basis, has turned futile….

[23]. To conclude, we find that except her physical ability, the victim is neither intellectually nor on social, personal, financial or family fronts, is able to bear and raise a child. We are satisfied with the reports of the Experts that the victim is incapable of understanding the concept of motherhood or of pregnancy or pre and post delivery implications. The victim, notwithstanding her innocent emotional expressions, is not mentally in a position to bear and raise the child. Asking her to continue with the pregnancy and thereafter raise the child would be a travesty of justice and a permanent addition to her miseries. The "toy" with which she wants to play, would want her to invest hugely which she is incapable of.

…

[29]. We would now advert to the facts and circumstances of the case in hand in the context of some-what broadly acceptable globalised view point. The victim neither has family support, financial help, capacity to secure and earn livelihood nor is she physically and mentally capable to perform except a few simple manual jobs like dusting etc. Her IQ and maturity level has already been referred to in *extenso*. She, notwithstanding her physical age, is just a child mentally. In the existing system where, with no other choice, she is forced to live, we have no hesitation in observing

that she is extremely vulnerable to all types of deceptive, dishonest and immoral offers even at the hands of those whom the law bestowed with the duty of looking-after her. …

[30]. ... Would it not be mere poetic justice if we, notwithstanding our profound belief, are swayed by the emotional hue and cry made on behalf of a physically grown but mentally weak person who does not understand the consequences of what she is asking for…or should we allow the victim to liberate herself from the forced physical, mental, moral and social responsibility which she is neither capable of shouldering nor aware of as to how has she been burdened with it? We firmly hold that notwithstanding the ambiguous responses given by the victim to some members of the Expert Body, who have erroneously though *bona-fidely* believed as if she is keen, with full informed knowledge of the present and future consequences, on bearing the child, the victim in the case in hand deserves to be liberated from this agonizing responsibility which has been forced upon her, by way of brutal acts of her mental childhood having been ravished.

[31]. It needs equal emphasis that the case in hand unequivocally certifies the ingredients of *Explanation-1* to Section 3 [2] of the 1971 Act. We say so on the basis of over-whelming material on record in support of such conclusion. The Evaluation Report dated 25th May, 2009 submitted by the Board comprising a Psychiatrist, Clinical Psychologist and an eminent Social Worker reveals that at the time of her examination, the victim had stopped enjoying "watching TV etc. as she used to earlier". She would even feel bad when forced to watch TV and '**SHE ALSO CRIES ALMOST DAILY'.** The fact that she informed the Expert Body constituted by us that "she did not like the sexual act" and the manner in which she expressed her anguish when her clothes were torn during the unwilling and fully resisted sexual encounter. It is pertinent to mention that the victim has been able to exhibit her anguish even when she has no clear idea of a female or a male form, a sexual act or its attendant emotions.

[32]. The victim has expressed her anguish and strong resentment against the assault on her person, however, due to her inability to understand the sexual act or as to how the conception or development of the foetus takes place and how a child is born, that she could not co-relate her anguish with the act of the rape committed on her. It is in this back-drop that the so-called consent given by the victim for retention of her pregnancy has to be evaluated. What she has consented for is something which she has absolutely no knowledge of. ... What she has consented for is only to have a child not knowing the meaning of pregnancy and how has it taken place or how a child is born. She can not make any distinction between her own child

or of someone else's and just needs a child to play with. The inference of consent drawn from such innocent expressions of the victim is, thus, highly deceptive and not based upon her knowledge regarding the present or future implications, responsibilities and the social fall-outs. An un-informed statement like that is no 'consent' in the eyes of law.

[33]. Contrary to it and given the mental condition of the victim or her suspected physical disability, we have no reason to doubt that the continuation of the pregnancy shall constitute a grave injury and may lead to more deterioration in the mental health of the victim.

...

[35]. For the reasons stated above and in continuity of our previous order dated 9th June, 2009, we direct the petitioner– Administration to act promptly and forthwith medically terminate the pregnancy of the victim in terms of Para 38 of our previous order dated 9th June, 2009.

…

**On Appeal to the Supreme Court**

## Judgment

…

2. A Division Bench of the High Court of Punjab and Haryana in C.W.P. No. 8760 of 2009, by orders dated 9.6.2009 and 17.7.2009, ruled that it was in the best interests of a mentally retarded woman to undergo an abortion. The said woman (name withheld, hereinafter `victim') had become pregnant as a result of an alleged rape that took place while she was an inmate at a government-run welfare institution located in Chandigarh. After the discovery of her pregnancy, the Chandigarh Administration, which is the respondent in this case, had approached the High Court seeking approval for the termination of her pregnancy, keeping in mind that in addition to being mentally retarded she was also an orphan who did not have any parent or guardian to look after her or her prospective child. The High Court had the opportunity to peruse a preliminary medical opinion and chose to constitute an Expert Body consisting of medical experts and a judicial officer for the purpose of a more thorough inquiry into the facts. .... In such cases, the presumption is that the findings of the Expert Body would be given due weightage in arriving at a decision. However, in its order dated 17.7.2009 the High Court directed the

termination of the pregnancy in spite of the Expert Body's findings which show that the victim had expressed her willingness to bear a child.

3. Aggrieved by these orders, the appellants moved this Court and the second appellant - Ms. Tanu Bedi, Adv. appeared in person on 20.7.2009 and sought a hearing on an urgent basis because the woman in question had been pregnant for more than 19 weeks at that point of time. We agreed to the same since the statutory limit for permitting the termination of a pregnancy, i.e. 20 weeks was fast approaching. … After hearing the counsel at length we had also considered the opinions of some of the medical experts who had previously examined the woman in question. … [W]e had granted a stay on the High Court's orders thereby ruling against the termination of the pregnancy.

4. The rationale behind our decision hinges on two broad considerations. The first consideration is whether it was correct on part of the High Court to direct the termination of pregnancy without the consent of the woman in question. This was the foremost issue since a plain reading of the relevant provision in the Medical Termination of Pregnancy Act, 1971 clearly indicates that consent is an essential condition for performing an abortion on a woman who has attained the age of majority and does not suffer from any `mental illness'. As will be explained below, there is a clear distinction between `mental illness' and `mental retardation' for the purpose of this statute. The second consideration before us is that even if the said woman was assumed to be mentally incapable of making an informed decision, what are the appropriate standards for a Court to exercise `Parens Patriae' jurisdiction? If the intent was to ascertain the `best interests' of the woman in question, it is our considered opinion that the direction for termination of pregnancy did not serve that objective. Of special importance is the fact that at the time of hearing, the woman had already been pregnant for more than 19 weeks and there is a medico-legal consensus that a late-term abortion can endanger the health of the woman who undergoes the same.

…

8. Since there was no clear statutory basis for proceeding with the abortion, the Chandigarh Administration moved the High Court of Punjab and Haryana seeking a judicial opinion on the said matter. … [T]he High Court directed the authorities to constitute an Expert Body consisting of medical experts and framed a set of questions to be answered by this Body. The High Court stressed on the need for ensuring that this Expert Body would be independent from the administrative

control or any form of influence by the Chandigarh Administration. The intention was that the Expert Body's findings would enable the High Court to ascertain the `best interests' of the woman in question. …

TERMINATION OF PREGNANCY CANNOT BE PERMITTED WITHOUT THE CONSENT OF THE VICTIM IN THIS CASE

10. Even though the Expert Body's findings were in favour of continuation of the pregnancy, the High Court decided to direct the termination of the same in its order dated 17.7.2009. We disagree with this conclusion since the victim had clearly expressed her willingness to bear a child. Her reproductive choice should be respected in spite of other factors such as the lack of understanding of the sexual act as well as apprehensions about her capacity to carry the pregnancy to its full term and the assumption of maternal responsibilities thereafter. We have adopted this position since the applicable statute clearly contemplates that even a woman who is found to be `mentally retarded' should give her consent for the termination of a pregnancy. In this regard we must stress upon the language of Section 3 of the Medical Termination of Pregnancy Act, 1971 [Hereinafter also referred to as `MTP Act'] …

…

11. A plain reading of the above-quoted provision makes it clear that Indian law allows for abortion only if the specified conditions are met. When the MTP Act was first enacted in 1971 it was largely modelled on the Abortion Act of 1967 which had been passed in the United Kingdom. The legislative intent was to provide a qualified `right to abortion' and the termination of pregnancy has never been recognised as a normal recourse for expecting mothers. There is no doubt that a woman's right to make reproductive choices is also a dimension of `personal liberty' as understood under Article 21 of the Constitution of India. It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Furthermore, women are also free to choose birth-control methods such as undergoing sterilisation procedures. Taken to their logical conclusion, reproductive rights include a woman's entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children. However, in the case of pregnant women there is also a `compelling state interest' in protecting the

life of the prospective child. Therefore, the termination of a pregnancy is only permitted when the conditions specified in the applicable statute have been fulfilled. Hence, the provisions of the MTP Act, 1971 can also be viewed as reasonable restrictions that have been placed on the exercise of reproductive choices.

12. A perusal of the above mentioned provision makes it clear that ordinarily a pregnancy can be terminated only when a medical practitioner is satisfied that a `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' [as per Section 3(2)(i)] or when `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' [as per Section 3(2)(ii)]. While the satisfaction of one medical practitioner is required for terminating a pregnancy within twelve weeks of the gestation period, two medical practitioners must be satisfied about either of these grounds in order to terminate a pregnancy between twelve to twenty weeks of the gestation period. The explanations to this provision have also contemplated the termination of pregnancy when the same is the result of a rape or a failure of birth-control methods since both of these eventualities have been equated with a `grave injury to the mental health' of a woman. In all such circumstances, the consent of the pregnant woman is an essential requirement for proceeding with the termination of pregnancy. This position has been unambiguously stated in Section 3(4)(b) of the MTP Act, 1971. The exceptions to this rule of consent have been laid down in Section 3(4)(a) of the Act. Section 3(4)(a) lays down that when the pregnant woman is below eighteen years of age or is a `mentally ill' person, the pregnancy can be terminated if the guardian of the pregnant woman gives consent for the same. The only other exception is found in Section 5(1) of the MTP Act which permits a registered medical practitioner to proceed with a termination of pregnancy when he/she is of an opinion formed in good faith that the same is `immediately necessary to save the life of the pregnant woman'. Clearly, none of these exceptions are applicable to the present case.

13. In the facts before us, the State could claim that it is the guardian of the pregnant victim since she is an orphan and has been placed in government-run welfare institutions. However, the State's claim to guardianship cannot be mechanically extended in order to make decisions about the termination of her pregnancy. An ossification test has revealed that the physical age of the victim is around 19-20 years. This conclusively shows that she is not a minor. Furthermore, her condition has been described as that of `mild mental retardation' which is clearly different from the condition of a `mentally ill person' as contemplated by Section 3(4)(a) of the MTP Act. It is pertinent to note that the MTP Act had been amended in 2002, by way of which the word `lunatic' was replaced by the expression `mentally

ill person' in Section 3(4)(a) of the said statute. The said amendment also amended Section 2(b) of the MTP Act, where the erstwhile definition of the word `lunatic' was replaced by the definition of the expression `mentally ill person' which reads as follows:

"2(b) `mentally ill person' means a person who is in need of treatment by reason of any mental disorder other than mental retardation."

14. The 2002 amendment to the MTP Act indicates that the legislative intent was to narrow down the class of persons on behalf of whom their guardians could make decisions about the termination of pregnancy. It is apparent from the definition of the expression `mentally ill person' that the same is different from that of `mental retardation'. A similar distinction can also be found in the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995. This legislation treats `mental illness' and `mental retardation' as two different forms of `disability'. …

…

15. .... These legislative provisions clearly show that persons who are in a condition of `mental retardation' should ordinarily be treated differently from those who are found to be `mentally ill'. While a guardian can make decisions on behalf a `mentally ill person' as per Section 3(4)(a) of the MTP Act, the same cannot be done on behalf of a person who is in a condition of `mental retardation'. The only reasonable conclusion that can be arrived at in this regard is that the State must respect the personal autonomy of a mentally retarded woman with regard to decisions about terminating a pregnancy. It can also be reasoned that while the explicit consent of the woman in question is not a necessary condition for continuing the pregnancy, the MTP Act clearly lays down that obtaining the consent of the pregnant woman is indeed an essential condition for proceeding with the termination of a pregnancy. As mentioned earlier, in the facts before us the victim has not given consent for the termination of pregnancy. We cannot permit a dilution of this requirement of consent since the same would amount to an arbitrary and unreasonable restriction on the reproductive rights of the victim. We must also be mindful of the fact that any dilution of the requirement of consent contemplated by Section 3(4)(b) of the MTP Act is liable to be misused in a society where sex-selective abortion is a pervasive social evil.

16. Besides placing substantial reliance on the preliminary medical opinions presented before it, the High Court has noted some statutory provisions in the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act…

where the distinction between `mental illness' and `mental retardation' has been collapsed. The same has been done for the purpose of providing affirmative action in public employment and education as well as for the purpose of implementing anti-discrimination measures. The High Court has also taken note of provisions in the IPC which lay down strong criminal law remedies that can be sought in cases involving the sexual assault of `mentally ill' and `mentally retarded' persons. The High Court points to the blurring of these distinctions and uses this to support its conclusion that `mentally ill' persons and those suffering from `mental retardation' ought to be treated similarly under the MTP Act, 1971. We do not agree with this proposition. We must emphasize that while the distinction between these statutory categories can be collapsed for the purpose of empowering the respective classes of persons, the same distinction cannot be disregarded so as to interfere with the personal autonomy that has been accorded to mentally retarded persons for exercising their reproductive rights.

TERMINATION OF PREGNANCY IS NOT IN THE `BEST INTERESTS' OF THE VICTIM

17. In the impugned orders, the High Court has in fact agreed with the proposition that a literal reading of Section 3 of the MTP Act would lead to the conclusion that a mentally retarded woman should give her consent in order to proceed with the termination of a pregnancy. However, the High Court has invoked the doctrine of `Parens Patriae' while exercising its writ jurisdiction to go beyond the literal interpretation of the statute and adopt a purposive approach. The same doctrine has been used to arrive at the conclusion that the termination of pregnancy would serve the `best interests' of the victim in the present case even though she has not given her consent for the same. We are unable to accept that line of reasoning

18. The doctrine of `Parens Patriae' has been evolved in common law and is applied in situations where the State must make decisions in order to protect the interests of those persons who are unable to take care of themselves. Traditionally this doctrine has been applied in cases involving the rights of minors and those persons who have been found to be mentally incapable of making informed decisions for themselves. Courts in other common law jurisdiction have developed two distinct standards while exercising Parens Patriae' jurisdiction for the purpose of making reproductive decisions on behalf of mentally retarded persons. These two standards are the `Best interests' test and the `Substituted judgment' test.

19. 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 other stakeholders such as guardians or 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.

20. The application of the `Substituted Judgment' test requires the court to step into the shoes of a person who is considered to be mentally incapable and attempt to make the decision which the said person would have made, if she was competent to do so. This is a more complex inquiry but this test can only be applied to make decisions on behalf of persons who are conclusively shown to be mentally incompetent. In the present case the victim has been described as a person suffering from `mild mental retardation'. This does not mean that she is entirely incapable of making decisions for herself. The findings recorded by the Expert Body indicate that her mental age is close to that of a nine-year old child and that she is capable of learning through rote-memorisation and imitation. Even the preliminary medical opinion indicated that she had learnt to perform basic bodily functions and was capable of simple communications. In light of these findings, it is the `Best Interests' test alone which should govern the inquiry in the present case and not the `Substituted Judgment' test.

21. We must also be mindful of the varying degrees of mental retardation - namely those described as borderline, mild, moderate, severe and profound instances of the same. Persons suffering from severe and profound mental retardation usually require intensive care and supervision and a perusal of academic materials suggests that there is a strong preference for placing such persons in an institutionalised environment. However, persons with borderline, mild or moderate mental retardation are capable of living in normal social conditions even though they may need some supervision and assistance from time to time. A developmental delay in mental intelligence should not be equated with mental incapacity and as far as possible the law should respect the decisions made by persons who are found to be in a state of mild to moderate `mental retardation'.

22. In the present case, the victim has expressed her willingness to carry the pregnancy till its full term and bear a child. The Expert body has found that she has a limited understanding of the idea of pregnancy and may not be fully prepared for assuming the responsibilities of a mother. As per the findings, the victim is physically capable of continuing with the pregnancy and the possible risks to her physical health are

similar to those of any other expecting mother. There is also no indication that the prospective child may be born with any congenital defects. However, it was repeatedly stressed before us that the victim has a limited understanding of the sexual act and perhaps does not anticipate the social stigma that may be attached to a child which will be born on account of an act of rape. Furthermore, the medical experts who appeared before us also voiced the concern that the victim will need constant care and supervision throughout the pregnancy as well as for the purposes of delivery and childcare after birth. Maternal responsibilities do entail a certain degree of physical, emotional and social burdens and it was proper for the medical experts to gauge whether the victim is capable of handling them. The counsel for the respondent also alerted us to the possibility that even though the victim had told the members of the Expert Body that she was willing to bear the child, her opinion may change in the future since she was also found to be highly suggestible.

23. Even if it were to be assumed that the victim's willingness to bear a child was questionable since it may have been the product of suggestive questioning or because the victim may change her mind in the future, there is another important concern that should have been weighed by the High Court. At the time of the order dated 17.7.2009, the victim had already been pregnant for almost 19 weeks. By the time the matter was heard by this Court on an urgent basis on 21.7.2009, the statutory limit for terminating a pregnancy, i.e. 20 weeks, was fast approaching. There is of a course a cogent rationale for the provision of this upper limit of 20 weeks (of the gestation period) within which the termination of a pregnancy is allowed. This is so because there is a clear medical consensus that an abortion performed during the later stages of a pregnancy is very likely to cause harm to the physical health of the woman who undergoes the same. This rationale was also noted in a prominent decision of the United States Supreme Court in Roe v. Wade, 410 US 113 (1973), which recognised that the right of a woman to seek an abortion during the early-stages of pregnancy came within the constitutionally protected `right to privacy'. Even though this decision had struck down a statutory provision in the State of Texas which had criminalized the act of undergoing or performing an abortion, (except in cases where the pregnancy posed a grave risk to the health of the mother) it had also recognised a `compelling state interest' in protecting the life of the prospective child as well as the health of the pregnant woman after a certain point in her the the gestation period. …

24. In light of the above-mentioned observations, it is our considered opinion that the direction given by the High Court (in its order dated 17.7.2009) to terminate the victim's pregnancy was not in pursuance of her `best interests'. Performing an abortion at such a late-stage could have endangered the victims' physical health and

the same could have also caused further mental anguish to the victim since she had not consented to such a procedure. We must also mention that the High Court in its earlier order had already expressed its preference for the termination of the victim's pregnancy (See Para. 38 in Order dated 9.6.2009) even as it proceeded to frame a set of questions that were to be answered by a Expert Body which was appointed at the instance of the High Court itself. In such a scenario, it would have been more appropriate for the High Court to express its inclination only after it had considered the findings of the Expert Body.

25. Our conclusions in this case are strengthened by some norms developed in the realm of international law. For instance one can refer to the principles contained in the United Nations Declaration on the Rights of Mentally Retarded Persons, 1971 [G.A. Res. 2856 (XXVI) of 20 December, 1971] which have been reproduced below:-

"1. The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.

2. The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

3. The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities.

4. Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.

5. The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.

6. The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.

7. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become

necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities."

26. Special emphasis should be placed on Principle 7 (cited above) which prescribes that a fair procedure should be used for the `restriction or denial' of the rights guaranteed to mentally retarded persons, which should ordinarily be the same as those given to other human beings. In respecting the personal autonomy of mentally retarded persons with regard to the reproductive choice of continuing or terminating a pregnancy, the MTP Act lays down such a procedure. We must also bear in mind that India has ratified the Convention on the Rights of Persons with Disabilities (CRPD) on October 1, 2007 and the contents of the same are binding on our legal system.

27. The facts of the present case indeed posed some complex questions before us. While we must commend the counsel for their rigorous argumentation, this case also presents an opportunity to confront some social stereotypes and prejudices that operate to the detriment of mentally retarded persons. Without reference to the present proceedings, we must admit to the fact that even medical experts and judges are unconsciously susceptible to these prejudices. … We have already stressed that persons who are found to be in borderline, mild and moderate forms of mental retardation are capable of living in normal social conditions and do not need the intensive supervision of an institutionalised environment. As in the case before us, institutional upbringing tends to be associated with even more social stigma and the mentally retarded person is denied the opportunity to be exposed to the elements of routine living. For instance, if the victim in the present case had received the care of a family environment, her guardians would have probably made the efforts to train her to avoid unwelcome sexual acts. However, the victim in the present case is an orphan who has lived in an institutional setting all her life and she was in no position to understand or avoid the sexual activity that resulted in her pregnancy. The responsibility of course lies with the State and fact-situations such as those in the present case should alert all of us to the alarming need for improving the administration of the government-run welfare institutions.

28. It would also be proper to emphasize that persons who are found to be in a condition of borderline, mild or moderate mental retardation are capable of being good parents. Empirical studies have conclusively disproved the eugenics theory that mental defects are likely to be passed on to the next generation. The said

`Eugenics theory' has been used in the past to perform forcible sterilisations and abortions on mentally retarded persons. … We firmly believe that such measures are anti-democratic and violative of the guarantee of `equal protection before the law' as laid down in Article 14 of our Constitution. It is also pertinent to note that a condition of `mental retardation' or developmental delay is gauged on the basis of parameters such as Intelligence Quotient (I.Q.) and Mental Age (M.A.) which mostly relate to academic abilities. It is quite possible that a person with a low I.Q. or M.A. may possess the social and emotional capacities that will enable him or her to be a good parent. Hence, it is important to evaluate each case in a thorough manner with due weightage being given to medical opinion for deciding whether a mentally retarded person is capable of performing parental responsibilities.

## CONCLUSION AND DIRECTIONS

29. With regard to the facts that led to the present proceeding, the question of whether or not the victim was capable of consenting to the sexual activity that resulted in her pregnancy will be addressed in the criminal proceedings before a trial court. An FIR has already been filed in the said matter and two security-guards from Nari Niketan are being investigated for their role in the alleged rape.

30. The substantive questions posed before us were whether the victim's pregnancy could be terminated even though she had expressed her willingness to bear a child and whether her `best interests' would be served by such termination. As explained in the fore-mentioned discussion, our conclusion is that the victim's pregnancy cannot be terminated without her consent and proceeding with the same would not have served her `best interests'. In our considered opinion, the language of the MTP Act clearly respects the personal autonomy of mentally retarded persons who are above the age of majority. Since none of the other statutory conditions have been met in this case, it is amply clear that we cannot permit a dilution of the requirement of consent for proceeding with a termination of pregnancy. We have also reasoned that proceeding with an abortion at such a late stage (19-20 weeks of gestation period) poses significant risks to the physical health of the victim. Lastly, we have urged the need to look beyond social prejudices in order to objectively decide whether a person who is in a condition of mild mental retardation can perform parental responsibilities.

31. The findings recorded by the Expert body which had examined the victim indicate that the continuation of the pregnancy does not pose any grave risk to the physical or mental health of the victim and that there is no indication that the prospective child is likely to suffer from a congenital disorder. However, concerns have been

expressed about the victim's mental capacity to cope with the demands of carrying the pregnancy to its full term, the act of delivering a child and subsequent childcare. In this regard, we direct that the best medical facilities be made available so as to ensure proper care and supervision during the period of pregnancy a well as for post-natal care. Since there is an apprehension that the woman in question may find it difficult to cope with maternal responsibilities, the Chairperson of the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities (constituted under the similarly named 1999 Act) has stated in an affidavit that the said Trust is prepared to look after the interests of the woman in question which will include assistance with childcare. In the said affidavit, it has been stated that this Trust will consult the Chandigarh Administration as well as experts from the Post Graduate Institute of Medical Education and Research (PGIMER) in order to ensure proper care and supervision. If any grievances arise with respect to the same subject matter in the future, the respondent can seek directions from the High Court of Punjab and Haryana under its writ jurisdiction.

...

# Nikhil Datar v. Union of India, Bombay High Court WPL 1816/2008, Supreme Court SLP 5334/2009

## Synopsis

In this case, the Bombay High Court rejected a claim that medical termination of pregnancy should be available after 20 weeks in cases of severe foetal abnormality. The Court held that Section 5 of the Medical Termination of Pregnancy Act, 1971, providing for abortion after 20 weeks where the mother's life is at risk, was distinct from Section 3, which allows for abortion of a foetus of less than 20 weeks for multiple reasons, including foetal abnormality. The case is currently on appeal to the Supreme Court.

### Facts

In 2008, Mrs. X discovered her foetus had a congenital heart block at her routine 24-week prenatal checkup. Assuming her foetus survived, doctors told her that the child would likely face a lifetime of disability. Given the poor prospects for her child's life, Mrs. X and her husband sought medical termination of the pregnancy. However, under the Medical Termination of Pregnancy Act, 1971 (MTP Act), she could not get an abortion for a foetal abnormality after 20 weeks due to the fact that Section 5 of the MTP Act only allows medical termination of pregnancy after 20 weeks if the mother's life is at risk. Because of the impact of the foetus's abnormality on Mrs. X's mental health, she, her husband, and Dr. Datar sought a judicial authorization for abortion from the Bombay High Court.

### Relevant Law

*Constitution*: Article 21 (right to a dignified life)
*Statutes & Schemes*: Medical Termination of Pregnancy Act, 1971
*International Law*: *K.L. v. Perú*, 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).

## Outcome

Ultimately, the Bombay High Court decided that because the pregnancy was beyond 20 weeks, the pregnancy could not be terminated, as the mother's life was not at risk. The Court rejected the petitioners' argument that Sections 3 and 5 of the MTP Act should

be read together, such that a serious foetal defect causing significant mental harm to the mother should be a reason to permit an abortion after 20 weeks. In its reasoning, the Court emphasized that these two sections of the Act were clearly separate, both in terms of the statute's plain language and legislative intent. It argued that to read the MTP Act any other way would be to overstep its bounds and undermine the legislature's authority. As such, the Court denied judicial authorization to terminate Mrs. X's pregnancy.

Still, the petitioners argue that denying an abortion for cases of severe foetal abnormality when the pregnancy is past 20 weeks violates women's right to be free from cruel, inhuman, and degrading treatment under international law, as well as women's right to a dignified life under Article 21 of the Constitution of India. The case has been appealed to the Supreme Court, and is currently pending.

## Judgment – Bombay High Court

…

2. By the present petition, the petitioners are seeking declaration that Section 5 of The Medical Termination of Pregnancy Act, 1971, for short "the said Act", to the extent it does not include the eventualities specified under Section 3(2)(b)(ii) of the said Act is ultra vires and that, therefore, the Section 5(1) of the said Act should be read down to include the said eventualities, and consequently should be read to include the following words "and when 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" and hence direction should be issued to the respondents to allow [Mrs. X] to terminate the pregnancy.

3. The facts which are not in dispute are that [Mrs. X] is currently in 26th week of pregnancy. During 24th week of pregnancy, [Mrs. X] having undergone the necessary medical tests learnt that the foetus in her womb was diagnosed to have congenital complete heart block. [Mr. and Mrs. X] consulted [Dr. Datar] and sought his opinion about the possibility for termination of pregnancy after learning about the alleged anomalies in the foetus.

4. It is the case of the petitioners that though the termination of pregnancy has been advised, on account of statutory provisions comprised under the said Act, the doctors are reluctant to perform the necessary surgical operation in that regard.

5. The petition when came up for hearing on 29th July, 2008, after hearing the parties, by reasoned order, this Court (Sri J.N. Patel and Sri K.K. Tated, JJ) required the Chief Medical Officer/Dean of J.J.Hospital to constitute a Committee of gynaecologist

and paediatrician experts in the field of Cardiology and to submit the report after examining [Mrs. X] on the aspect of termination of pregnancy. Accordingly, report was submitted and the matter came up for hearing on 1st August, 2008.

6. On 1st August, 2008, after going through the report, it was observed by this Court (Sri P.B. Majmudar and Sri A.A. Sayed, JJ) that:

Prima facie, we find contradiction in the report and since the Court is not in a position to get a clear picture from the report of the Committee, as at one place the Committee has said that on medical reasons the Committee feels that the findings do not have substantive significance to resort the termination of pregnancy and at another place it says that the Committee is of the opinion that there are very fair chances that child will be born incapacitated and handicapped to survive.

Having observed as above, the Court issued the following direction:

... Let the Government Pleader also communicate this order to the Dean, J.J.Hospital, Mumbai, requesting the Committee Members to give further report as indicated above. Looking to the urgency of the matter, the Committee may give additional report by giving firm finding in this behalf by preparing the report latest by tomorrow evening. The Dean, J.J.Hospital may hand over the additional report/opinion in a sealed envelope giving their findings as indicated above to the Government Pleader before 10.00 a.m. on 4th August, 2008 so that such report can be made available to the Court when the matter is taken up for hearing. The learned Counsel for [Mrs. X[ submitted that [she] may be granted liberty to get herself examined through an expert Paediatrist/ Cardiologist/ Gynaecologist and submit report in this behalf. It is for [Mrs. X] to adopt such course. At this stage, we are not expressing any opinion.

7. Today, when the matter came up for hearing in the morning session, the report in terms of order dated 1st August, 2008 was placed before us. The said report reads thus:

As per the orders of the Honble Court, Ms. Niketa Mehta has been examined by following 3 specialists and they have submitted their reports which are annexed for your kind perusal: …

After discussing with all the 3 specialists, the finding seen on Sonography, the following observations are recorded:

1) The lady has 24 weeks gestation.
2) The fetal echocardiogram reports can be accurate in observations upto 80 to 85 % of the actual findings. Nowhere in the world findings can be 100% accurate.

3) Sonographic examination shows complete heart block with a ventricular rate of 50-55 per minute and heart is structurally and functionally normal.
4) Great arteries are in mal position (L-malposition) without any other structural defects and it is viable to normal life provided there are no other structural anomalies in the heart.
5) In the echocardiogram done outside, no other structural anomalies are identified.
6) Only small percentage of kids will be symptomatic and will require implantation of the pace make costing less than, one lakh of rupees which will be replaced by adult pace make at a later date, leading to normal life.

The consensus of the committee is that whatever is visualized and opined by the Gynaecologist from the pertaining area may not be 100% truth. The committee is of the opinion that there are very least chances that child will be born incapacitated and handicapped to survive. On medical reasons, the committee feels that the findings observed do not have substantive significance to resort the termination of pregnancy. However, it is the liberty of the patient to choose continuation of the pregnancy after knowing the reality.

8. On 1st August, 2008, the petitioners also had sought an opportunity to get [Mrs. X] examined through an expert and submit a report in that regard and accordingly, the learned advocate for the petitioners has submitted the opinion of Dr. Snehalata Deshmukh, Dr. Shakuntala Prabhu and Dr. Snehal Kulkarni. The report of Dr. Snehalata Deshmukh reads thus:

As per your interim order the petitioners have sought my opinion in the subject matter.

This opinion is given strictly on the basis of professional experience as Pediatric Surgeon and after studying the reports produced by the petitioner. I have also reviewed the relevant literature.

I state as under.

1) Quality of life for this child is likely to be severely compromised. There is every possibility that this child may be incapacitated & handicapped. The risk is substantial risk if child were born.
2) The age of viability in Indian context is around 26-28 weeks of pregnancy.

9. The provision of law, as comprised under Section 3(1) of the said Act, provides that notwithstanding anything contained in the Indian Penal Code, 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 the said Act. Sub-section (2) of Section 3 of the said Act

provides that subject to the provisions of Sub-section (4), a pregnancy may be terminated by a registered medical practitioner, where the length of the pregnancy does not exceed twelve weeks, if such medical practitioner is, or 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 - 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 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. ... Sub-section (3) thereof provides that in determining whether the continuance of a 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 reasonable foreseeable environment. …

10. Section 5 of the said Act, which is yet another section dealing with the pregnancy, in its Sub-section (1) provides that the provisions of Section 4, and so much of the provisions of Sub-section (2) of Section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. ...

11. The above provisions of law comprised under the said Act clearly disclose the circumstances under which pregnancy can be terminated. Undoubtedly, Section 5 of the said Act relates to the right of a pregnant woman to terminate pregnancy in case it is found necessary to save her life. Section 5 nowhere speaks of any right of a pregnant woman to terminate the pregnancy on the ground that delivery of a child may result in some abnormalities in or to the child to be born. It strictly restricts to the cases where life of the pregnant woman would be in danger in case the pregnancy is not terminated and does not refer to any other circumstances. Undoubtedly, the opinion in that regard has to be formed by a registered medical practitioner and such opinion should be in good faith. The expression "good faith" discloses that the opinion has to be based on the necessary examination required to form such an opinion.

12. As far as Section 3(2)(b)(ii) is concerned, it clearly speaks of right to terminate the pregnancy where there is a substantial risk in allowing the child to take birth as it would suffer from such physical or mental abnormalities as to be seriously handicapped. However, such right is restricted to the maximum period of twenty weeks of pregnancy and not beyond it. Section 3(2)(b)(ii) is very clear in that regard. It also provides that before opting for such pregnancy within the said period, it is

necessary for two registered medical practitioners to form an opinion in good faith for termination of the pregnancy. In case, the pregnancy has not exceeded twelve weeks, then such an opinion can be formed in good faith by any one medical practitioner.

13. In the case in hand, the opinion expressed by the Committee which was constituted pursuant to the direction of this Court has clearly opined that "there are very least chances that child will be born incapacitated and handicapped to survive. On medical reasons, the committee feels that the findings observed do not have substantive significance to resort the termination of pregnancy."

14. The findings which have been arrived at on examination of [Mrs. X] and various reports of her medical examination and which have been reproduced in the earlier part of the order, undoubtedly refer to "complete heart block with a ventricular rate of 50-55 per minute,"; however, it also discloses the finding to the effect that "heart is structurally and functionally normal. Great arteries are in mal position (L-malposition) without any other structural defects and it is viable to normal life provided there are no other structural anomalies in the heart. In the echocardiogram done outside, no other structural anomalies are identified. Only small percentage of kids will be symptomatic and will require implantation of the pace maker costing less than, one lakh of rupees which will be replaced by adult pace make at a later date, leading to normal life."

15. The report which is submitted on behalf of the petitioners, that of Dr. Snehalata Deshmukh, nowhere discloses possibilities of any physical or other abnormalities of serious nature having been noted by the doctor, or that the opinion has been formed to the effect that there is a every possibility that the child may be incapacitated and handicapped. The report on the face of record nowhere discloses the opinion having been formed on the basis of any finding arrived at by the concerned expert about possible abnormalities in the child on or after its birth on the basis of examination of the reports.

16. As far as the report by Dr. Shakuntala Prabhu and Dr. Snehal Kulkarni is concerned, it is in the form of questions and answers. The report discloses that the questions were posed by [Dr. Datar] and they were answered by the said two doctors. With reference to the question regarding the findings on examination, the doctors have stated that the upper two chambers beating at rate of 133 per minute, and Lower two chambers beating at 50 per minute suggest functional abnormality; the atrioventricular connections are abnormal (av discordance). Vessel which needs to arise from right ventricle arises from left and vice a versa, (av discordance) suggest structural anomaly. As regards the question regarding diagnosis, it was stated that

"corrected transposition of great vessels with complete heard block." To the question as to whether there are only two defects noticed and will the same require cardiac surgery at or after birth of child, the answer was in the negative, and further it was stated that "on post delivery sonography, 50% of babies show additional defects, and in such cases, cardiac surgery would be required." To the specific question as to whether in the opinion of doctors, whether the child would need a pace maker at birth or afterwards, it was stated that "the literature shows that 80% patients need pace maker with heart block and since the heart rate is very slow, it is surely required pace maker at birth." To the question as to whether the pace maker is a one time solution to the problem, the same was answered in the negative. It was further stated that:

Q. Is pacemaker a one time solution to problem?
Ans: No. Pacemaker has to be changed again. Average interval of change is 4-5 years.

Q. Are there any complications associated with pacemaker?
Ans: Since it is a surgical procedure it has its own set of complications such as infections, risk of anaestheia.

Q. Is pacemaker put in clinic?
Ans: No.

Q. Do you need hospital, ICCU, operation theatre for the procedure?
Ans: Yes. It cant be put in clinic and patient sent home. It needs hi tech operation theatre to perform procedure.

Q. After putting the pacemaker will child be able to sleep, run, swim etc. like all other children.
Ans: Definitely there will be restrictions on activities and it may affect quality of life.

Q. If any such activity is undertaken by the child what will be the problem?
Ans: The child may have heart arrythmia, sudden death. failure,

Q. Can this fetus develop "hydrops foetalis" (swelling all over the body) and what are the effects on the foetal brain?
Ans: Yes. There is high possibility and can have detrimental effects on fetal brain.

Q. How may children with this abnormality have you seen who are leading totally normal life?
Ans: hardly anybody.

Q. If you would have faced the same problem in your family, would you consider the problem as "substantive risk to fetal life"?

Ans: Yes. We both of are the opinion that in such set of anomaly, there is a substantial risk that if child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

17. Undoubtedly, the opinion given by Dr. Shakuntala Prabhu and Dr. Snehal Kulkarni refers to the possibility of "a substantial risk if the child were born it would suffer from physical or mental abnormalities as to be seriously handicapped." However, the opinion itself discloses the necessary treatment which is required to be given to overcome the problem which the child on its birth may face, apart from the fact that considering the defects as they are noticed today, both the doctors are not sure that cardiac surgery would be required at or after the birth to the child and according to them, it would all depend upon post delivery sonography to be conducted. The question No. 3 and answer thereto is very clear in this regards and reads thus:

Q.3 Since there are only two defects noticed, can you surely say that the cardiac surgery will not be required at/after birth?

Ans: No. On post delivery sonography, 50% of babies show additional defects. In such cases cardiac surgery is required.

Being so, taking into consideration the opinion expressed by the doctors committee from J.J.Group of Hospital as well as the Two Expert Committee of two doctors which was constituted by the petitioners themselves, there is no categorical opinion before us from the medical experts to the effect that "if the child were born, it would suffer from physical or mental abnormalities as to be seriously handicapped." Apart from the fact that already the period of 26 weeks of pregnancy has passed, even the requirements of the provisions of law under Section 3(2)(ii) read with Section 3(2)(b) are not satisfied. In other words, even if the petitioners were to approach this Court before the expiry of 20 weeks of pregnancy, based on the medical opinion placed before us, it would not have been possible for this Court to issue direction for exercise of right in terms of Section 3 of the said Act.

18. It was sought to be argued on behalf of the petitioners that the pre-amble of the said Act clearly provides that there is avoidable wastage of the mothers health, strength and, sometimes, life, and therefore, the legislation in the form of the said Act seeks to liberalise certain existing provisions relating to termination of pregnancy which is nothing but a health measure in cases where there is danger to the life or risk to physical or mental health of the woman as also on humanitarian grounds such as when pregnancy arises from a sex crime like rape or intercourse

with a lunatic woman, etc., and where there is substantial risk that the child, if born, would suffer from deformities and diseases, and considering the eventualities under which the pregnancy can be terminated in terms of Section 3, the same should be read in Section 5 also. According to the learned Advocate, there was lapse on the part of the legislators in not including such eventualities under Section 5 of the said Act and relying upon the decision of the Apex Court in the matter of Union of India India v. Association for Democratic Reforms and Anr. reported in MANU/SC/0394/2002, the learned advocate for the petitioners submitted that the said lacuna is required to be filled in by reading down Section 5 to include such eventualities.

19. We are afraid the contention on behalf of the petitioners if accepted would virtually amount to legislating upon Section 5 of the said Act. Under the guise of reading down a provision of law, the Courts are not empowered to legislate upon a statute. That is essentially the function of the legislature.

20. The Statement of Objects and Reasons of the said Act undoubtedly discloses that the legislation in the nature of the said Act was enacted to regulate the matters in relation to the termination of certain pregnancies. Sections 3 and 5 clearly speak of right to terminate pregnancy under the specified circumstances and after taking necessary precautions and after obtaining medical opinion of the medical experts who are required to give their opinion in good faith in that regard. Section 5 can be resorted to for termination of pregnancy when the non-termination of pregnancy would be dangerous to the life of pregnant woman. It is not a mere desire to terminate the pregnancy that will entitle either pregnant woman to go for termination of pregnancy or for the doctors to assist the pregnant woman to terminate the pregnancy by taking resort to Section 5 of the said Act. There has to be an opinion formed in good faith by a medical experts in that regard before going for termination of pregnancy. Undoubtedly, the experts have to ascertain whether there is danger to the life of a pregnant woman on account of pregnancy.

21. As regards the physical or mental abnormalities of serious nature to the child to be born which could be the cause for termination of pregnancy, the legislature in its wisdom has imposed certain period within which the pregnancy can be terminated. Nothing is placed on record on behalf of the petitioners even to remotely suggest that the period so prescribed by the statute has been arbitrarily prescribed or that there is no logic behind the period prescribed by the legislature in that regard.

22. In the circumstances, the petitioners have not placed on record even any material which could perhaps justify the exercise of our discretion in writ jurisdiction to allow [Mrs. X] to terminate the pregnancy. No exceptional case in that regard has been made out so as to exercise discretionary jurisdiction under Article 226 of the Constitution of India to issue any writ in the matter.

…

25. It was clearly held by the Apex Court in Divisional Manager, Aravali Golf Club & Anr. v. Chander Hass and Anr. reported in 2008 AIR SCW 406 that the judiciary cannot encroach into the domain of the legislature or executive. In P. Ramchandra Rao v. State of Karnataka reported in, it was ruled that the doctrine of separation of powers envisages that the legislature should make law, the executive should execute it, and the judiciary should settle disputes in accordance with the existing law. ... It was specifically held that making of an entirely new law, through directions, is not a legitimate judicial function. Further in Union of India and Anr. v. Deoki Nandan Aggarwal reported in AIR 1992 SC 96 : 1991 AIR SCW 2754 it was held that it is not the duty of the Court either to enlarge the scope of the legislation or the intention of the legislature when the language of the provision is plain and unambiguous. The Court cannot rewrite, recast or reframe the legislation for the very good reason that it has no power to legislate. ... Assuming there is a defect or an omission in the words used by the legislature, the Court could not go to its aid to correct or make up the deficiency. …

26. For the reasons stated above, we find no case is made out for the reliefs asked for. Hence, the petition fails and is hereby dismissed. …

# Child Marriage

## 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, 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 lead 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 47% of girls are married before the age of 18 in present-day India. 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

## Outcome

In response to the PIL, almost all Indian states responded by filing affidavits. Most of these states have awareness programs for the prevention of child marriages, such as compulsory registration and recording of marriages. Because these measures have been largely ineffective in combating the central issue, the Supreme Court directed the State to take stronger measures against child marriage. The Central Government responded by setting into motion the Prevention of Child Marriage Bill in 2004, which was passed in 2006. Despite this ostensible progress, many communities still defend the traditional practice of child marriage. In May 2005, local villagers attacked Shakuntala Verma, an anganwadi worker, with a machete after she inquired into the prevalence of child marriage in the area.

With respect to the Prevention of Child Marriage Bill, the Court ordered: "We, however, hope and trust that in the meantime district and states officials shall make every endeavour to prevent child marriages as far as possible, and preferably in cases where mass marriages take place." This case has been joined with related cases on child marriage and is still pending before the Court.

## 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

1 Suicide is second only to maternal mortality as the cause of death for women in India aged 15-25. Kounteya Sinha, Suicide may soon be leading cause of death, reveals study, Times of India, June 22, 2012.

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 therefrom. 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 for as possible and preferably in cases where mass marriages take place.

In that view of the matter let the case be 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.

It is expected that the States within six weeks, thereafter, shall frame appropriate Rules.

# Coercive Population Measures

## Javed & Ors. v. State of Haryana, Supreme Court AIR 2003 SC 3057

### Synopsis

As a measure to enforce and promote the two-child norm, in 1994 the State of Haryana introduced a measure prohibiting individuals with more than two children from serving as Sarpanch or Panch, the elected leaders of a Gram Panchayat (village government), as well as in several other local government posts. Ultimately, the Court upheld the prohibition because the village leaders are supposed to serve as an example to the community, and promoting the two-child norm is a value the government can legitimately promote.

### Facts

Under Sections 175(1)(q) and 177(1) of the Haryana Panchayati Raj Act, 1994, no person with more than two children could serve in local government as Sarpanch or Panch of a Gram Panchayat, or stand as a member of a Panchayat Samiti or Zila Parishad. The disqualification provision went into effect one year after the Act was passed. Thus, the birth of any children conceived up to three months after the Act's passage would not serve to disqualify their parents from the government posts; this was intended to give adequate time for people to learn of the law. In addition, the Act included a provision for resolving disputes about whether individuals were disqualified under the law. One stated objective in passing this law was to promote the Family Welfare/Family Planning Programme, which aims to promote the two-child norm and encourage family planning methods to limit family size.

The Petitioners, all individuals who had been disqualified under the Act, argued "(i) that the provision is arbitrary and hence violative of Article 14 of the Constitution; (ii) that the disqualification does not serve the purpose sought to be achieved by the legislation; (iii) that the provision is discriminatory; (iv) that the provision adversely affects the liberty of leading personal life in all its freedom and having as many children as one chooses to have and hence is violative of Article 21 of the Constitution; and (v) that the provision interferes with freedom of religion and hence violates Article 25 of the Constitution."

**Relevant Law**

*Constitution*: Articles 14 (right to equal protection), 21 (right to a dignified life), & 25 (freedom of religion)
*Cases*: *Air India v. Nergesh Meerza and Ors.* 1981 AIR 1829 (The Court upheld a rule dismissing airline hostesses who became pregnant while having two living children as a constitutionally valid means to check the growing population)
*Statutes & Schemes*: Haryana Panchayati Raj Act, 1994

## Outcome

According to the Supreme Court, the Act satisfied due process requirements by postponing the enforcement date by one year, thus leaving space for the birth of any children conceived around the time the Act was passed, and by providing adequate procedures for disputing one's disqualification under the Act.

Article 14 of the Constitution prohibits arbitrary classifications and discrimination based on sex, race, class, caste, religion, and place of birth. The constitutional test for acceptable classifications is that the resulting categories must be intelligibly different and the classification must be reasonably related to an object of the statute. Here, the Court found that the distinction between people with two children and people with more than two children was clear and non-arbitrary. Because the statute aimed to promote the two-child norm, the Court found it was rational to distinguish between people with only two children and people with more than two, and to bar the latter from serving in the enumerated local government positions.

The Petitioners argued that the ban was discriminatory because officials in other local government posts did not face disqualification based on their number of children. The Court rejected this argument, stating that the government may gradually phase in the implementation of new policies. Further, because each state decides its own rules and procedures for local government, there was no discrimination in the fact that only Haryana residents suffered disqualification based on number of children, while residents of other states faced no such provision.

In addition, the Petitioners' alleged that the law violated their rights to life and religion under Articles 21 and 25 because, based on their desired family composition or religious beliefs about contraception and family size, they could be disqualified from running for local government positions. In analyzing this claim, the Court first pronounced that the right to contest an election is not a fundamental right, and thus likely did not fall under the protection of Articles 21 and 25. Nevertheless, the Court examined the provision in the light of Articles 21 and 25.

The Petitioners argued that their right to decide the number and spacing of their children was a component of their right to a dignified life under Article 21. In rejecting this claim, the Court underscored that the reasonableness of any restriction on individual rights must be examined in light of the well-being of the nation as a whole, and in consideration of the Constitution's Directives of State Policy under which the State aspires to promote social and economic justice. Referencing India's burgeoning population, the Court stated that provisions to disincentivize individuals from having more than two children could be a reasonable restriction on individual rights.

Finally, with respect to freedom of religion under Article 25, the Petitioners argued that many religions promote procreation and the sanctity of the family. Thus, they claimed the Act's disqualification punished them for practicing their religion. The Court rejected this argument as well, emphasizing that no religion in India requires having more than two children. For the law to violate the Petitioners' right to religion a practice cannot simply be permitted or encouraged by a religion, it must instead be required.

## Judgment

…

2. In this batch of writ petitions and appeals the core issues is the vires of the provisions of Section 175(1)(q) and 177(1) of the Haryana Panchayati Raj Act, 1994 (Act No. 11 of 1994) (hereinafter referred to as the Act, for short). The relevant provisions are extracted and reproduced hereunder:-

   "175. (1) No person shall be a Sarpanch or a Panch of a Gram Panchayat or a member of a Panchayat Samiti or Zila Parishad or continue as such who -

   …

   (q) has more than two living children :

   Provided that a person having more than two children on or upto the expiry of one year of the commencement of this Act, shall not be deemed to be disqualified;

   "177(1) If any member of a Gram Panchayat, Panchayat Samiti or Zila Parishad -

   (a) who is elected, as such, was subject to any of the disqualifications mentioned in Section 175 at time of his election;

   (b) during the term for which he had been elected, incurs any of the disqualifications mentioned in Section 175, shall be disqualified from continuing to be a member and his office shall become vacant.

   (2) In every case, the question whether a vacancy has arisen shall be decided by the Director. The Director may give its decision either on an application made to it by any person, or on its own motion. Until the Director decides that the vacancy, has arisen, the members shall not be disqualified under Sub-section (1) for continuing to be a member. Any person aggrieved by the decision of the

Director may, within a period of fifteen days from the date of such decision, appeal to the Government and the orders passed by Government in such appeal shall be final:

Provided that no order shall be passed under this sub-section by the Director against any member without giving him a reasonable opportunity of being heard."

3. … One of the objectives set out in the Statement of Objects and Reasons is to disqualify person for election of Panchayats at each level, having more than 2 children after one year of the date of commencement of this Act, to popularize Family Welfare/Family Planning Programme (Vide Clause (m) of Para 4 of SOR).

4. Placed in plain words the provision disqualifies a person having more than two living children from holding the specified offices in Panchayats. The enforcement of disqualification is postponed for a period of one year from the date of the commencement of the Act. ... This postponement for one year takes care of any conception on or around the commencement of the Act, the normal period of gestation being nine months. … If the factum is disputed the Director is entrusted with the duty of holding an enquiry and declaring the office vacant. ... The Director has to afford a reasonable opportunity of being heard to the holder of office sought to be disqualified. These safeguards satisfy the requirements of natural justice.

5. Several persons (who are the writ petitioners or appellants in this batch of matters) have been disqualified or proceeded against for disqualifying either from contesting the elections for, or from continuing in, the office of Panchas/Sarpanchas in view of their having incurred the disqualification as provided by Section 175(1)(q) or Section 177(1) read with Section 175(1)(q) of the Act. .... As agreed to at the Bar, the grounds of challenge can be categorized into five :- (i) that the provision is arbitrary and hence violative of Article 14 of the Constitution; (ii) that the disqualification does not serve the purpose sought to be achieved by the legislation; (iii) that the provision is discriminatory; (iv) that the provision adversely affects the liberty of leading personal life in all its freedom and having as many children as one chooses to have and hence is violative of Article 21 of the Constitution; and (v) that the provision interferes with freedom of religion and hence violates Article 25 of the Constitution.

…

Submissions (i), (ii) & (iii)

7. The first three submissions are based on Article 14 of the Constitution and, therefore, are taken up together for consideration.

**Is the classification arbitrary?**

8. It is well-settled that Article 14 forbids class legislation; it does not forbid reasonable classification for the purpose of legislation. To satisfy the constitutional test of permissibility, two conditions must be satisfied, namely (i) that the classification is founded on an intelligible differentia which distinguishes persons or things that are grouped together from others left out of the group, and (ii) that such (sic) has a rational relation to the object sought to be (sic) by the Statute in question. The basis for classification may rest on conditions which may be geographical or according to objects or occupation or the like. [See : Constitution Bench decision in Budhan Choudhry and Ors. v. The State of Bihar]. The classification is well-defined and well-perceptible. Persons having more than two living children are clearly distinguishable from persons having not more than two living children. ... One of the objects sought to be achieved by the legislation is popularizing the family welfare/family planning programme. The disqualification enacted by the provision seeks to achieve the objective by creating a disincentive. The classification does not suffer from any arbitrariness. The number of children, viz., two is based on legislative wisdom. It could have been more or less. The number is a matter of policy decision which is not open to judicial scrutiny.

**The legislation does not serve its object?**

9. It was submitted that the number of children which one has, whether two or three or more, does not affect the capacity, competence and quality of a person to serve on any office of a Panchayat and, therefore, the impugned disqualification has no nexus with the purpose sought to be achieved by the Act. There is no merit in the submission. We have already stated that one of the objects of the enactment is to popularize Family Welfare/Family Planning Programme. This is consistent with the National Population Policy.

10. Under Article 243G of the Constitution the Legislature of a State has been vested with the authority to make law endowing the Panchayats with such powers and authority which may be necessary to enable the Gram Panchayat to function as institutions of self-Government and such law may contain provisions for the devolution of powers and responsibilities upon Panchayats, at the appropriate level, subject to such conditions as may be specified therein. Clause (b) of Article 243G

provides that Gram Panchayats may be entrusted the powers to implement the schemes for economic development and social justice….

The family welfare would include family planning as well. To carry out the purpose of the Act as well as the mandate of the Constitution the Legislature has made a provision for making a person ineligible to either contest for the post of Panch or Sarpanch having more than two living children. Such a provision would serve the purpose of the Act as mandated by the Constitution. It cannot be said that such a provision would not serve the purpose of the Act.

11. In our opinion, the impugned disqualification does have a nexus with the purpose sought to be achieved by the Act. Hence it is valid

**The provision is discriminatory?**

12. It was submitted that though the State of Haryana has introduced such a provision of disqualification by reference to elective offices in panchayats, a similar provision is not found to have been enacted for disqualifying aspirants or holders of elective or public offices in other institutions [of government].... So also all the States, i.e., other than Haryana have not enacted similar laws…. Under the constitutional scheme there is a well-defined distribution of legislative powers contained in Part XI of the Constitution. The Parliament and every State Legislature has power to make laws with respect to any of the matters which fall within its field of legislation under Article 246 read with Seventh Schedule of the Constitution. A legislation by one of the States cannot be held to be discriminatory or suffering from the vice of hostile discrimination as against its citizens simply because the Parliament or the Legislatures of other States have not chosen to enact similar laws. Such a submission if accepted would be violative of the autonomy given to the center and the States within their respective fields under the constitutional scheme.

…

16. A uniform policy may be devised by the center or by a State. However, there is no constitutional requirement that any such policy must be implemented in one-go. Policies are capable of being implemented in a phased manner. More so, when the policies have far-reaching implications and are dynamic in nature, their implementation in a phased manner is welcome for it receives gradual willing acceptance and invites lesser resistance.

…

18. To make a beginning, the reforms may be introduced at the grass-root level so as to spiral up or may be introduced at the top so as to percolate down. Panchayats

are grass-root level institutions of local self-governance. They have a wider base. There is nothing wrong in the State of Haryana having chosen to subscribe to the national movement of population control by enacting a legislation which would go a long way in ameliorating health, social and economic conditions of rural population, and thereby contribute to the development of the nation which in its turn would benefit the entire citizenry. We may quote from the National Population Policy 2000 (Government of India Publication, page 35):-

"Demonstration of support by elected leaders, opinion makers, and religious leaders with close involvement in the reproductive and child health programme greatly influences the behavior and response patterns of individuals and communities. This serves to enthuse communities to be attentive towards the quality and converge of maternal and child health service's including referral care."....."The involvement and enthusiastic participation of elected leaders will ensure dedicated involvement of administrators at district and sub-distinct levels. Demonstration of strong support to the small family norm, as well as personal example, by political, community, business, professional, and religious leaders, media and film stars, sports personalities and opinion makers, will enhance its acceptance throughout society."

19. No fault can be found with the State of Haryana having enacted the legislation. It is for others to emulate.

20. We are clearly of the opinion that the impugned provision is neither arbitrary nor unreasonable nor discriminatory. The disqualification contained in Section 175(1) (q) of Haryana Act No. 11 of 1994 seeks to achieve a laudable purpose - socio-economic welfare and health care of the masses and is consistent with the national population policy. It is not violative of Article 14 of the Constitution.

**Submission (iv) & (v) : the provision if it violates Article 21 or 25?**

21. Before testing the validity of the impugned legislation from the viewpoint of Articles 21 and 25, in the light of the submissions made, we take up first the more basic issue - Whether it is at all permissible to test the validity of a law which enacts a disqualification operating in the field of elections on the touchstone of violation of fundamental rights?

22. Right to contest an election is neither a fundamental right nor a common law right. It is a right conferred by a Statute. At the most, in view of Part IX having been added in the Constitution, a right to contest election for an office in Panchayat may be said to be a constitutional right…. But even so it cannot be equated with a fundamental right. There is nothing wrong in the same Statute which confers the

right to contest an election also to provide for the necessary qualifications without which a person cannot offer his candidature for an elective office and also to provide for disqualifications which would disable a person from contesting for, or holding, an elective statutory office.

…

25. In our view, disqualification on the right to contest an election by having more than two living children does not contravene any fundamental right nor does it cross the limits of reasonability. Rather it is a disqualification conceptually devised in national interest.

…

**The disqualification if violates Article 21?**

27. Placing strong reliance on Mrs. Maneka Gandhi v. Union of India and Anr., and Kasturu Lal Lakshmi Reddy and Ors. v.State of Jammy and Kashmir and Anr., it was forcefully urged that the fundamental right to life and personal liberty emanating from Article 21 of the Constitution should … include in the compendious term of the Article all the varieties of rights which go to make up the personal liberty of man including the right to enjoy all the materialistic pleasures and to procreate as many children as one pleases.

28. At the very outset we are constrained to observe that the law laid down by this Court in the decisions relied on is either being misread or red divorced of the context. The test of reasonableness is not a wholly subjective test and its contours are fairly indicated by the Constitution. ... The lofty ideals of social and economic justice, the advancement of the nation as a whole and the philosophy of distributive justice - economic, social and political - cannot be given a go-by in the name of run due stress on fundamental rights and individual liberty. Reasonableness and rationality, legally as well as philosophically, provide colour to the meaning of fundamental rights and these principles are deducible from those very decisions which have been relied on by the learned counsel for the petitioners.

29. It is necessary to have a look at the population scenario, of the world and of our own country.

30. India has the (dis)credit of being second only to China at the top in the list of the 10 most-populous countries of the world. As on 1.2.2000 the population of China was 1,277.6 million while the population of India as on 1.3.2001 was 1,027.0 million (Census of India, 2001, Series I, India - Paper I of 2001, page 29).

31. The torrential increase in the population of the country is one of the major hindrances in the pace of India's socio-economic progress. ... It is a matter of regret that though the Constitution of India is committed to social and economic justice for all, yet India has entered the new millennium with the largest number of illiterates in the world and the largest number of people below the poverty line. The laudable goals spelt out in the Directive Principles of State Policy in the Constitution of India can best be achieved if the population explosion is checked effectively. ...

…

33. In the beginning of this century, the world population crossed six billions, of which India alone accounts for one billion (17 per cent) in a land area of 2.5 per cent of the world area. The global annual increase of population is 80 millions. Out of this, India's growth share is over 18 millions (23 per cent), equivalent to the total population of Australia, which has two and a half times the land space of India. In other words, India is growing at the alarming rate of one Australia every year and will be the most densely populous country in the world, out beating China, which ranks fist, with a land area thrice this country's. ... Here, the per capita crop land is the lowest in the world, which is also shrinking fast. If this falls below the minimum sustained level, people can no longer feed themselves ... It is emphasized that as the population grows rapidly there is a corresponding decrease in per capita water and food. Women in many places trek long distances in search of water which distances would increase every next year on account of excessive ground water withdrawals catering to the need of the increasing population, resulting in lowering the levels of water tables.

34. ... China, the most populous country in the world, has been able to control its growth rate by adopting the 'carrot and stick' rule. Attractive incentives in the field of education and employment were provided to the couples following the 'one-child norm'. At the same time drastic disincentives were cast on the couples breaching 'one-child norm' which even included penal action. India being a democratic country has so far not chosen to go beyond casting minimal disincentives and has not embarked upon penalizing procreation of children beyond a particular limit. However, it has to be remembered that complacence in controlling population in the name of democracy is too heavy a price to pay, allowing the nation to drift towards disaster.

…

38. None of the petitioners has disputed the legislative competence of the State of Haryana to enact the legislation. ... The legislation is within the permitted field of State subjects. Article 243C makes provision for the Legislature of a State enacting

laws with respect to Constitution of Panchayats. ... Article 243G casts one of the responsibilities of Panchayats as preparation of plans and implementation of schemes for economic development and social justice. ... Family planning is essentially a scheme referable to health, family welfare, women and child development and social welfare. Nothing more needs to be said to demonstrate that the Constitution contemplates Panchayat as a potent instrument of family welfare and social welfare schemes coming true for the betterment of people's health especially women's health and family welfare coupled with social welfare. …

39. Fundamental rights are not to be read in isolation. They have to be read along with the Chapter on Directive Principles of State Policy and the Fundamental Duties enshrined in Article 51A. Under Article 38 the State shall strive to promote the welfare of the people and developing a social order empowered at distributive justice - social, economic and political. Under Article 47 the State shall promote with special care the educational and economic interests of the weaker sections of the people and in particular the constitutionally down-trodden. Under Article 47 the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties. None of these lofty ideals can be achieved without controlling the population inasmuch as our materialistic resources are limited and the claimants are many. The concept of sustainable development which emerges as a fundamental duty from the several clauses of Article 51A too dictates the expansion of population being kept within reasonable bounds.

40. The menace of growing population was judicially noticed and constitutional validity of legislative means to check the population was upheld in Air India v. Nergesh Meerza and Ors. The Court found no fault with the rule which would terminate the services of Air Hostesses on the third pregnancy with two existing children, and held the rule both salutary and reasonable for two reasons – "In the first place, the provision preventing a third pregnancy with two existing children would be in the larger interest of the health of the Air Hostess concerned as also for the good upbringing of the children. Secondly...when the entire world is faced with the problem of population explosion it will not only be desirable but absolutely essential for every country to … meet the danger of over-population which, if not controlled, may lead to serious social and economic problems throughout the world."

41. To say the least it is futile to assume or urge that the impugned legislation violates right to life and liberty guaranteed under Article 21 in any of the meanings howsoever expanded the meanings may be.

**The provisions if it violates Article 25?**

42. It was then submitted that the personal law of Muslims permits performance of marriages with 4 women, obviously for the purpose of procreating children and any restriction thereon would be violative of right to freedom of religion enshrined in article 25 of the Constitution. The relevant part of Article 25 reads as under:-

> 25. Freedom of conscience and free profession, practice and propagation of religion. - (1) Subject to public order, morality and health and to the other provisions of this Part, all persons are equally entitled to freedom of conscience and the right freely to profess, practise and propagate religion.

43. A bare reading of this Article deprives the submission of all its force…. The freedom is subject to public order, morality and health. So the Article itself permits a legislation in the interest of social welfare and reform which are obviously part and parcel of public order, national morality and the collective health of the nation's people.

44. The Muslim Law permits marrying four women. The personal law nowhere mandates or dictates it as a duty to perform four marriages. ... In our view, the question of the impugned provision of Haryana Act being violative of Article 25 does not arise. …

…

51. What constitutes social reform? Is it for the legislature to decide the same? Their Lordships held in Narasu Appa Mali's case (supra) that the will expressed by the legislature, constituted by the chosen representatives of the people in a democracy who are supposed to be responsible for the welfare of the State, is the will of the people and if they lay down the policy which a State should pursue such as when the legislature in its wisdom has come to the conclusion that monogamy tends to the welfare of the State, then it is not for the Courts of Law to sit in judgment upon that decision. Such legislation does not contravene Article 25(1) of the Constitution.

…

53. The Division Bench of the Bombay High Court in Narasu Appa Mali (supra) also had an occasion to examine the validity of the legislation when it was sought to be implemented not in one go but gradually. Their Lordships held – "Article 14 does not lay down that any legislation that the State may embark upon must necessarily be of an all-embracing character. The State may rightly decide to bring about social reform by stages and the stages may be territorial or they may be community-wise."

…

59. In our view, a statutory provision casting disqualification on contesting for, or holding, an elective office is not violative of Article 25 of the Constitution.

60. Looked at from any angle, the challenge to the constitutional validity of Section 175(1)(q) and Section 177(1) must fail. The right to contest an election for any office in Panchayat is neither fundamental nor a common law right. It is the creature of a statute and is obviously subject to qualifications and disqualifications enacted by legislation. …[N]o religion in India dictates or mandates as an obligation to enter into bigamy or polygamy or to have children more than one. ... A practice does not acquire the sanction of religion simply because it is permitted. Assuming the practice of having more wives than one or procreating more children than one is a practice followed by any community or group of people the same can be regulated or prohibited by legislation in the interest of public order, morality and health or by any law providing for social welfare and reform which the impugned legislation clearly does.

61. If anyone chooses to have more living children than two, he is free to do so under the law as it stands now but then he should pay a little price and that is of depriving himself from holding an office in Panchayat in the State of Haryana. There is nothing illegal about it and certainly no unconstitutionality attaches to it.

**Some incidental questions**

62. It was submitted that the enactment has created serious problems in the rural population as couples desirous of contesting an election but having living children more than two, are feeling compelled to give them in adoption. .... Merely because the couple has parted with one child by giving the child away in adoption, the disqualification does not come to an end. While interpreting the scope of disqualification we shall have to keep in view the evil sought to be cured and purpose sought to be achieved by the enactment. If the person sought to be disqualified is responsible for or has given birth to children more than two who are living then merely because one or more of them are given in adoption the disqualification is not wiped out.

63. It was also submitted that the impugned disqualification would hit the women worst, inasmuch as in the Indian society they have no independence and they almost helplessly bear a third child if their husbands want them to do so. This contention need not detain us any longer. A male who compels his wife to bear a third child would disqualify not only his wife but himself as well. We do not think that with the awareness which is arising in Indian women folk, they are so helpless as to be

compelled to bear a third child even though they do not wish to do so. At the end, suffice it to say that if the legislature chooses to carve out an exception in favour of females it is free to do so but merely because women are not excepted from the operation of the disqualification it does not render it unconstitutional.

64. Hypothetical examples were tried to be floated across the bar by submitting that there may be cases where triplets are born or twins are born on the second pregnancy and consequently both of the parents would incur disqualification for reasons beyond their control or just by freak of divinity. Such are not normal cases and the validity of the law cannot be tested by applying it to abnormal situations. Exceptions do not make the rule nor render the rule irrelevant. …

## Conclusion

65. The challenge to the constitutional validity of Section 175(1)(q) and 177(1) fails on all the counts. ... The provisions are salutary and in public interest.…

…

# Maternal Health and HIV/AIDS

## Shanno Shagufta Khan v. State of Madhya Pradesh & Ors., High Court of Madhya Pradesh at Indore PIL W.P. 2341/2007, Supreme Court SLP (C) 11844/2012

### Synopsis

This case addresses the intersection between maternal health and discrimination against HIV/AIDS patients. Hospital staff in Madhya Pradesh denied treatment to Gitabai, an HIV positive woman in labor. Ultimately, Gitabai left the hospital and delivered her baby in an auto-rickshaw. As a result of the lack of care and unhygienic delivery, both she and her infant subsequently died. Though the MP High Court awarded some compensation and found the hospital staff had acted negligently, the petitioners appealed to the Supreme Court for orders directing the government to establish guidelines for the proper treatment of pregnant women with HIV/AIDS.

#### Facts

In March 2007, workers at a hospital in Madhya Pradesh denied Gitabai admission and basic emergency care notwithstanding that she was then going into labor. The only reason given was that she was an AIDS patient. Turned away from the hospital, Gitabai was forced to deliver her child in an auto-rickshaw. The woman and her baby later died. Advocate Shanno Shagufta Khan filed a PIL in the High Court of Madhya Pradesh at Indore to demand compensation and orders preventing the mistreatment of HIV+ people in the future.

#### Relevant Law

*Constitution*: Article 21 (right to a dignified life)
*Cases*: *Paschim Bengal Khet Mazdoor Samity & Ors. v. State of West Bengal & Anr., AIR 1996 SC 2426* (The State is obligated to provide adequate medical facilities and care, and a failure to do so violates the right to life guaranteed by Article 21)

#### Current Status

The High Court of Madhya Pradesh affirmed that the State is responsible for the negligence of health care workers employed at government hospitals and found that

Gitabai had indeed been treated negligently. In spite of this, however, the Court declined to hold any particular official liable for the utter failure to treat Gitabai, and awarded only Rs. 3 lakh to her family as compensation for her death and that of her baby. The Court also gave no orders with respect to reforms aimed at preventing similar violations of HIV+ patients' rights.

The petitioners filed a Special Leave Petition (SLP) at the Supreme Court and the case is currently pending. In their prayers to the Court, the petitioners allege the compensation of Rs. 3 lakh was illusory. They argue instead that at least Rs. 10 lakh should have been awarded for two deaths caused by severe negligence. Further, the petitioners seek additional orders directing reform in the hospitals and other health centres. The SLP also seeks criminal prosecution against the doctors and staff directly responsible for the deaths of Gitabai and her infant. Moreover, the appeal illuminates the systematic discrimination and negligent treatment HIV/AIDS patients suffer in India, and seeks comprehensive orders in that regard.

## Judgment – Madhya Pradesh High Court

1. The petitioner a practicing Advocate in this court, in Pro bono Publico, has filed this writ petition claiming compensation to the legal representatives of the deceased Gitabai who allegedly died on account of the negligence in medical treatment on the part of the respondents.

2. Case of the petitioner is that Gitabai was a pregnant and was referred to the M.Y. Hospital, Indore on 30.03.2007 from Rogi Kalyan Samity, Government Nehru Hospital, Burhanpur. Gitabai was suffering from HIV+ and was having acute labour pain. In M.Y. Hospital on 31.03.2007 OPD slip was issued to Gitabai, she was not admitted in the hospital and was forced to wait outside. After waiting for about four hours, when she along with her relatives was returning from hospital in a rickshaw, she delivered a child on the way. She was again brought to the M.Y. hospital on 01.04.2007 and on 02.04.2007 she was admitted in the M.Y. Hospital, but proper care was not taken and she was not given due medical treatment, consequently, she died on 03.03.2007 at 11:00PM. After about a month, the new born baby also dies. Mohar Singh, father-in-law of Gitabai made an application to the Superintendant, M.Y. Hosptial for taking action against the negligent doctors. Since there was no satisfactory response, therefore, the present writ petition was filed.

3. The respondent No. 1 to 5 have filed their reply dated 25.11.2007 taking the plea that Gitabai was suffering from AIDS and was given proper treatment when she had come to the hospital. They further took the stand that when she had come to the

hospital for the second time, she was found suffering from lung infection which had precipitated due to the presence of AIDS resulting into her death. She had not died of any problem due to pregnancy or delivery of child. They denied any ill-treatment or negligence on the part of the hospital staff. The other respondents have also taken similar stand. The respondent no.6 Dr. Anupama Dave has additionally stated that as per the protocol, Resident Surgical Officer(R.S.O) examine and admit the patient on their own judgment and inform on call lecturer and if any problem arises in management of the patient then on call Associate Professor is informed. Her further stand is that she was not informed by any RSP or on cal lecturer about this patient. The respondent no.7 Dr. Ranjana Patidar took the additional stand that she was available in the hospital when Gitabai had come to the M.Y. Hospital but was not made aware of the said patient. The respondent no. 8 to 11 in their reply have taken the additional plea that Gitabai was detected HIV+ on 31.03.2007 and was examined by RSO on duty and injection was administered to her and was advised to wait because at that time she was not in labour pain and there was sufficient time for delivery. They denied any negligence in her treatment.

…

5. The core question which arises for consideration is as to whether there was any negligence in the treatment of Gitabai in M.Y. Hospital on the relevant dates and the legal representatives of deceased Gitabai are entitled to any compensation in these proceedings from the respondents on that account?

…

7. In the matter of Paschim Bengal Khet Mazdoor Samity & Ors. v. State of West Bengal and another reported in AIR 1996 SC 2426, the Supreme Court has taken the view that a welfare state discharges its obligation for providing adequate medical facilities to the people by running hospitals and health care centre, and the medical officers employed therein are duty bound to extend medical assistance for preserving human life and a failure in this regard may result into a violation of right to life guaranteed under Article 21 …. The Supreme Court has held as under: -

"9. The constitution envisages the establishment of a welfare state…. In a welfare state the primary duty of the Government is to secure the welfare of the people providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare state. The Government discharges this obligation by running hospitals and health centres which provide medical care to the person seeking to avail those facilities. Article 21 imposes an obligation on the state to safeguard the right to life of every person. Preservation of human life is of paramount importance. The government hospital run by the State and the Medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of the Government hosp. to provide timely medical treatment to person in need of such treatment results in

violation of his right to life under article 21. In the present case there was a breach of the said right of Hakim Singh guaranteed under article 21 when he was denied treatment at the various Government hosp. which were approached even though his condition was very serious at that time and he was in need of immediate medical attention. Since the said denial of the right of Hakim Singh guaranteed under Article 21 was by office of the state in hosp run by the state, the state cannot avoid responsibility for such denial…"

8. In the matter of State of Haryana and others v. Smt. Santra reported in AIR 2000 SC 1888, the Supreme Court has taken the view that a breach of the duty on the part of the doctor towards the patient may give a cause of action for negligence and the patient may, on that basis, recover damages from his doctor. … The Supreme Court rejected the theory of Sovereign immunity while dealing with the argument of the State in respect of the vicarious liability….

9. In the matter of State of Haryana and others (supra) the Supreme Court further held that:-

"11. In two decision renderd by this Court…it was laid down that when a Doctor is consulted by a patient, the former, namely, the doctor owes to his patient certain duties which are (a) a duty of care in deciding whether to undertake the case, (b) a duty of care in deciding what treatment to give; and (c) a duty of care in the administration of that treatment. A breach of any of the above duties may give a cause of action for negligence and the patient may on that basis recover damages from his doctor. In a recent decision in Poonam Verma v. Ashwin Patel (1996) 4 SCC 382 :AIR 1996 SC 2111 : (1996 AIR SCW 2553) where the question of medical negligence was considered in the context of treatment of a patient, it was observed as under:-

"40. Negligence has many manifestation – it may be active negligence, collateral negligence, comparative negligence, concurrent negligence, continued negligence, criminal negligence, gross negligence, hazardous negligence, willful or reckless negligence or negligence per se, which is defined in Black's Law Dictionary as under:

> Negligence per se: conduct, whether of action or omission, which may be declared and treated as negligence without any argument or proof as to the particular surrounding circumstance, either because it is in violation of a statute or valid municipal ordinance, or because it is so palpably opposed to the dictates of common prudence that it can be said without hesitation or doubt that no careful person would have been guilty of it. As a general rule, the violation of a public duty, enjoined by law or the protection of person or property, so constitutes."

…

11. In the matter of M.P. Human Rights Commission v. State of M.P. and other reported in 2003 (1) MPLJ 410 while considering the issue of negligence in the eye camps organized by the State has held that:-

"23. In the case of Mohammed Aynuddin alias Miyam v. State of Andhra Pradesh, AIR 2000 SC 2511 the Apex Court has held that State is vicariously liable for negligence of its officers. … In a democratic set up a citizen has a right to lead a life as permitted within the constitutional framework and the state cannot do anything that would curtail or abridge the protected rights of a citizen. A citizen has a right to live with dignity. … The state has an obligation under law to take care of health of its citizen and cannot be allowed to do anything which would jeopardize the same."

…

14. A Magisterial inquiry [into Gitabai's death] was conducted by Sub-divisional Magistrate (SDM) City, Indore. During the course of managerial inquiry, the SDM had recorded the statements of the relatives of the deceased as well as the doctors, staff and other employees of the M.y.Hospital, Indore. The Sub Divisional Magistrate, in the inquiry report has reached to the conclusion that smt Gita bai was suffering from HIV positive and she died for this reason.it has been found in the report that on 31.03.2007 Gita Bai along with her relatives had come to M.Y. Hospital for treatment after being referred by the doctor from burhanpur. She was not admitted on that day in the hospital and necessary facilities were not mand available. Her family members were asked to come on 02.04.2007, since gitabai was suffering from HIV positive, therefore probably for this reason she was not admitted in the hospital and that the management and the doctor who were on duty in the labour room on 31.03.2007 in MY Hospital Indore were negligent in performing their duties. If Gita Bai would have been given proper treatment her immediate death could be postponed.

15. We have minutely examined the report submitted by Magistrate. The report clearly indivicates that there were lapses in the treatment of Gitabai in M.Y. Hospital. Such an inference is also inevitable considering the material which has been placed on record. We thus, reach to the conclusion that GeetaBai was not given proper medical treatment in the M.Y. Hospital for which the state is vicariously responsible. We make it clear that on the basis of material on record we do not find it safe, at this state in the proceedings under Article 226 of the Constitution, to fix the liability on any particular doctor, staff, or member of the management for such negligence.

16. [The Court then awarded damages to Gitabai's family.]

# Maternal Mortality and the Right to Health

Despite attempts to reduce the maternal mortality rate, India still accounts for most of the world's maternal deaths. To combat this, the government has enacted numerous benefit schemes to provide needed income, nutrition, and pre-natal, childbirth, and post-natal health care. The cases below illustrate human rights activists' efforts to enforce the implementation of these programmes and human rights protections through litigation.

## Centre for Health and Resource Management (CHARM) v. State of Bihar & Ors., High Court of Madhya Pradesh at Indore W.P. (C) 7650/2011

### Synopsis

Due in large part to its lack of adequate medical facilities and consistent denial of maternal health care to poor women, Bihar has one of the highest maternal mortality rates in India. Based on reports from the field, the Human Rights Law Network (HRLN) filed a Public Interest Litigation (PIL) on behalf of the Centre for Health and Resource Management (CHARM) to hold the State of Bihar accountable for its violations. The state was ordered to file quarterly status reports and to account for all National Rural Health Mission (NRHM) financing. As of winter 2012, the case is still pending in the Patna High Court.

#### Facts

In the whole of India, the state of Bihar has the highest poverty rate and one of the highest maternal mortality rates (MMR). Despite a landmark Delhi High Court decision holding that "the reproductive rights of the mother" are "inalienable survival rights" under Article 21, states like Bihar continually fail to provide adequate medical services to pregnant women and enforcement is relatively nonexistent. HRLN worked with local health activists to conduct a fact-finding in Munger District and discovered that the conditions of its existing health facilities were deplorable as they were overcrowded, unsanitary, and fraught with corruption.

In 2011, HRLN filed a PIL arguing that "the failure to ensure quality maternal healthcare and safe abortion services constitutes a violation of the right to be free from cruel, inhuman and degrading treatment due to the foreseeable physical and mental pain and

suffering caused to pregnant women." The petition focuses on impoverished women, whose only option is to rely on the government for health care. It requests the Court to order the state of Bihar to provide requisite services that meet NRHM standards, including health facilities, maternal health services, and abortion services, and to provide those services free of charge to women living below the poverty line.

### Relevant Law

*Constitution*: Article 21 (right to a dignified life)
*Cases*: *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others,* W.P. (C) 8853/2008; *Jaitun v. Maternal Home MCD, Jangpura & Others,* W.P. (C) 10700/2009 (holding that women have the right to survive pregnancy and childbirth)
*Statutes & Schemes*: NRHM

## Outcome

A Division Bench of the Patna Court filed interim orders instructing the Health Secretary of Bihar to provide status reports for each district and to account for the expenses covered by NRHM funding. Though the state filed the status reports, the Court ruled that these were unsatisfactory and ordered the state to file quarterly reports on its NRHM progress. The case is still pending.

## Orders

June 25, 2012
…
This Court is not satisfied with the contents of the counter affidavit filed by the respondents and accordingly further direction is given to the respondents to file a fresh counter affidavit indicating all the details with regard to medical facilities/equipments provided at Public Health Center to all the Districts and report in this regard should be filed quarterly after every three months.
…

# Centre for Youth and Social Action (CYSA) v. Nagaland, Gauhati High Court at Kohima W.P. (C) 62K/2008

## Synopsis

In *Centre for Youth and Social Action*, the petitioners seek recognition of malaria as a public health crisis in Nagaland. This disease is a particular danger to pregnant women, as their higher body temperature attracts more mosquitoes. Additionally, malaria contributes to severe complications and even death for pregnant women. The Gauhati High Court issued its final judgment in favor of the petitioners in September 2012.

### Facts

Due to medical negligence and the government's failure to provide proper staff, medical equipment and facilities, the State of Nagaland's anti-malarial policies have not been implemented. As a result, the lives and health of numerous residents are endangered. Indeed, Nagaland's MMR is significantly higher than that in the rest of India. In spite of these facts, the Nagaland government neither adequately tracked malarial infections and deaths, nor taken appropriate steps to remedy this public health crisis.

Malaria disproportionately affects marginalized groups who cannot afford mosquito nets and medications. Though mandated by law, the government has not provided bed nets to those who need them. The hazards posed by malaria are even more acute in the case of pregnant women. Because pregnancy raises the body temperature, mosquitoes are more attracted to pregnant women than other individuals. This exposes pregnant women to a serious hazard at a time when their bodies and the foetus are more vulnerable to life-threatening diseases like malaria. Therefore, the petition prays for the Court to direct the Nagaland government to comply with its own health directives for combating and treating malaria.

### Relevant Law

*Constitution*: Article 14 (right to equal protection) & 21 (right to a dignified life)
*Case Law*: *State of Punjab v. Mahinder Singh Chawla* (1997) 2 SCC 83 (affirming that "the right to health is integral to right to life"); *Paramanand Kataria v. Union of India* (1989) 4 SCC 286.
*Statutes & Schemes*: National Vector Borne Disease Control Programme (NVBDC)
*International law*: International Covenant on Economic Social and Cultural Rights

(ICESCR), Article 12(2)(c) (directing States Parties to undertake "[t]he prevention, treatment and control of epidemic, endemic, occupational and other diseases")

## Outcome

In response to the government's unjustified delays, the Court held the relevant officials in contempt, imposing a fine, and demanding the officials' presence at the next hearing. The Court emphasized that the officials' flippant attitude toward a significant public health crisis, which compromises the health and lives of mothers every day, was not acceptable. The High Court's final judgment/order directed the State of Nagaland to formulate "a comprehensive State Action Plan for eradication of malaria by way of anti malarial measures as per the national norms as formulated by the National Vector Borne Disease Control Programme" to preserve "human life from the scourge of malaria which has resurged in this Region." The Court also directed the state to create a high power monitoring body to "oversee the activities under the State Action Plan and to make emergent or remedial measures without bureaucratic sluggishness." The Court specifically directed the state to include members of NGOs and field workers "so as to harness peoples participation in the State Action Plan." The state has three months to frame and constitute the high power monitoring body (until December 2012).

## Orders

July 15, 2010

- No counter affidavit has been filed to this Writ petition although more than a year and half has gone by.
- We are told by the learned Addl. Advocate General that he has received a communication to the effect that the Officer In-charge of the case is too busy to find time to file a counter affidavit. We find this excuse to be simply ridiculous in view of the fact that the matter pertains to the health of the people of Nagaland, particularly, the people of Wokha District.
- We certainly cannot appreciate such a causal and irresponsible attitude on the part of the respondents.
- In the circumstances, we grant one last opportunity to the Respondents to file a counter affidavit subject to payment of costs of Rs. 10,000/-(Rupees ten thousand) which will be paid by means of a Demand Draft to be drawn in favour of the Registrar of this Court. The costs be deposited within three weeks from today.
- We also direct the Commissioner and Secretary, Government of Nagaland, Department of Health & Family Welfare, Nagaland (Respondent No. 2), The Principal Director, Department of Health & Family Welfare, Nagaland (Respondent No. 3) and the Project Director, National Vector Borne Disease Control Programme,

Kohima, Nagaland (Respondent No. 4) to be personally present in Court on 9.8.2010 at 10:30 AM.

- We make it clear that if the abovementioned three Officers fail to appear on the given date, proceedings will be initiated against them under the provisions of the Contempt of Courts Act.

…

## Judgment

Gauhati High Court, September 14, 2012

…

3. In the backdrop of resurgence of malaria several agencies have signaled alert. The *World Health Organisation* in the report titled as *Strategic Plan to Roll Back Malaria in the South-East Asia Region* has observed that:
"Malaria is occurring increasingly in the form of focal epidemics and the areas affected by the epidemic become endemic for malaria if the control measures are ineffective. Resistance to vectors is increasing and the cost of insecticides is becoming unaffordable thus rendering the control measures ineffective.
In the member countries, malaria is predominantly a disease of the poor, marginalized and vulnerable population. This is affecting the socio economic development adversely. According to WHO report in 2001, malaria leads to an estimated loss of 1.87 Disability adjusted Life Years (DALYs) in the countries of SEA Region each year. This amount to direct or indirect loss of about 3 billion US Dollars (USD) every year."

7. The petitioner on witnessing the deplorable state of the anti malaria measures as devised have filed this petition for intervention of this Court. Prior to that, the petitioners have surveyed two regions of the State of Nagaland and found that the Government reported '*a mortality rate for P. falciparum anywhere from 2% to 15% (i.e. 10 to 75 times higher than the national average.). In UMS Dimapur this rises to an incredibly high 65% mortality rate for P. falciparum in 2006 (325 times the national average.). In general, the high number of deaths in the State can be linked to staffing shortages, inadequate lab facilities, and improper treatment.'*

8. The petitioners urged for the direction for immediate implementation of the directives of *National Malaria Control Policy* having due regard to the local situations. The petitioners suggested the steps to:
   (i) Provide Artesunate Combination Therapy (ACT) as first line treatment for *P. falciparum* Malaria and Chloroquine as treatment fo P. Vivax malaria.

(ii) Appoint 667 malaria field workers for proper malaria surveillance and basis treatment i.e. 1 per 3,000/- populations.

(iii) Provide fieldworkers with any access to appropriate transport on call, telephone, back up of a doctor and primary health center.

(iv) Provide adequate number of Rapid Diagnostic Kits (RDK), life saving appropriate medication to the field workers.

(v) Appoint 100 lab technicians i.e. 1 per 20000 populations. Lab Technicians shall tie up and work with field workers.

(vi) Establish mobile malaria clinics to diagnose and treat patient in the villages.

(vii) Distribute long lasting Insecticide treated bed nets of adequate size to all families in need and explain the recipient how to use the net. All cases tested positive for malaria should be provided with the insecticide treated bed net.

(viii) Include testing and treatment for malaria as a part of ante-natal check up for all pregnant women in the long Janani Suraksha Yojana (JSY) and also provide Long Lasting Insecticide treated bed nets to all pregnant women in their first ante-natal check up or on registration of pregnancy.

(ix) Commence treatment of a *P. falciparum* malaria patient immediately i.e. within 24 hours after getting results of blood sample and full compliance of dosages taken to be observed.

(x) Conduct additional round of Indoor Residual Insecticide spray in all districts of Nagaland. However, it should be ensured that the spray is done systematically and the manpower is adequately trained poor to understanding the spray operations.

(xi) Fully equip the District Hospitals, PHCs and CHCs with necessary infrastructures, equipments drug and staff. Indoor facilities for admission of severe and complicated cases of malaria must be kept in readiness. The staff shall be trained to handle emergency malaria cases.

(xii) Create a Drug distribution centre in every village with adequate stocks of drugs, long lasting insecticide treated bed nets, rapid diagnostic kits and adequate stock of temophos for disinfecting household water.

(xiii) Develop follow up mechanism for *P. falciparum* cases until the parasite clearance.

(xiv) Appoint a departmental Technical Group to review and monitor the ongoing malaria situation and suggest necessary control measures.

9. The respondents by filing an Affidavit-in-Opposition have produced some records to show how the baseline surveys are being conducted to adopt the appropriate anti malarial measures.

…

16. This Court has scrutinized the documents/reports/data sheets as produced and

also considered the averments as advanced for the petitioners as well as for the State. It appears that there is a serious gap in the reported advance and the grass root reality. Due regard has been given to the preventive measures as stated to have been taken by the Government of Nagaland such as indoor residual spray, deployment of man Power, advance information and mobilizations for acceptance by the community, concurrent and consecutive supervision, compilation and analysis of reports on Malaria as filed by the field workers, supply of insecticide treated bed nets, distribution of Larvinorous fish, behavior communication change, capacity building and malaria curative aspects etc.

17. In most of the cases, the malaria positive cases are not being followed as per the National Drug Policy according to the data as available from the Government records. The health centres and health units are not being provided with anti malarial drugs for any eventuality as supplementing unit to support the anti malarial drive.

18. The apprehension as raised by the petitioners are rooted in the reality as exposed during the deliberation. In consideration thereof, we direct the State of Nagaland to formulate a comprehensive State Action Plan for eradication of malaria by way of anti malarial measures as per the national norms as formulated by the *NVBDCP* [National Vector Borne Disease Control Programme], *Malaria* Drug Policy (2007) and National Policy on Malaria for giving the direction to achieve the object of preserving the human life from the scourge of malaria which has resurged in this Region.

    It is further directed that under the State Action Plan, a high power monitoring body has to be created to oversee the activities under the State Action Plan and to make emergent of remedial measures without bureaucratic sluggishness. While constituting the said high power monitoring body, representatives from the non-Governmental Organisation or voluntary action groups (NGOs) working in the field be inducted so as to harness peoples participation in the State Action Plan. The said State Action Plan and the high power monitoring body have to be framed and constituted within a period not later than 3 (three) months from today.

19. The State has the Constitutional obligation under Article 47 to frame such policy as directed by this Court. While framing the said State Action Plan the steps as suggested by the petitioners be considered in the right spirit.

# Court Suo Moto v. Union of India, Delhi High Court W.P. (C) 5913/2010

## Synopsis

Shortly after *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors.* (W.P. (C) 8853/2008) was decided, the Delhi High Court instituted a suit on its own motion after media reported the death of Laxmi, a homeless woman who gave birth on the streets of Delhi. By failing to provide appropriate food, shelter, and health care, the state ultimately denied Laxmi her right to life under Article 21 of the Constitution. The Court ordered the Government of Delhi to immediately construct two shelters for destitute pregnant and lactating women and to begin the long-term process of ensuring proper maternal health care, nutrition, and shelter for women in need.

### Facts

In July 2010, Laxmi, a homeless woman, gave birth to a baby girl on a footpath in a busy Delhi neighborhood. After struggling to survive for four days, she finally succumbed to septicemia. Her baby, Karishma, was rescued by a neighborhood resident, Ms. Ritu Arthur Fredrik, and was thereafter placed in a children's home. On August 29, 2010, The Hindustan Times published Laxmi's story. Upon learning of the story, the Delhi High Court initiated a suit *suo moto*.

The Court asked the Human Rights Law Network to file an amicus brief about the present status of maternal health for destitute pregnant and lactating women in Delhi, and to suggest appropriate measures to rectify the situation. The amicus brief showed that in spite of various government schemes providing for food and health assistance to women and the poor, hospitals and government officials still fail to provide for those in need. As a direct result, impoverished pregnant and lactating women and their children are denied their rights to food, health, shelter, and life. Further, the Court ordered the government to detail what steps it had taken to comply with the Court's recent judgment in *Laxmi Mandal*, which issued specific orders to the government for protecting the lives and health of poor pregnant women and new mothers.

### Relevant Law

*Constitution*: Article 21 (right to a dignified life)
*Statutes & Schemes*: Antyodaya Anna Yojana (AAY), Integrated Child Development Scheme (ICDS), Janani Suraksha Yojana (JSY), National Family Benefit Scheme (NFBS), National Maternity Benefit Scheme (NMBS)

## Outcome

The Delhi High Court underscored the Government's failure to protect the life of Laxmi. In its order of October 20, 2010, the Court ordered the government to construct at least five shelters for homeless pregnant and lactating women providing around the clock food and medical facilities.

The government was also ordered to disseminate information on ICDS, NMBS, and other government schemes; keeping in mind that many intended beneficiaries are illiterate, the Court directed that information on schemes should be televised and broadcast by radio in Hindi. To provide information more directly, the government should also hold awareness camps in slum areas of Delhi. The Court also ordered the government to provide medical transportation to take women to the shelters or hospitals as needed. Finally, the Court emphasized that the government should partner with NGOs working in destitute communities to more efficiently implement these schemes and handle any cases that may arise from a failure to implement them.

At the January 12, 2011 hearing, the Government of Delhi filed an affidavit identifying several existing NGO-operated shelters in Delhi. However, HRLN lawyers pointed out that many of these shelters either lacked the capacity to care for more homeless women, or did not provide the services these women needed. Thus, the Court ordered the government to construct two appropriate shelters for pregnant and lactating women. In light of the Constitution's promise of the right to life under Article 21, the Court stressed that delay would not be countenanced.

At the next hearing, the government identified two shelters to be run by the Young Women's Christian Association (YWCA) and the All Indian Women's Conference. While agreeing in principle to these shelters being run by NGOs, the Court directed the government to post officials at each shelter to ensure accountability. The Court also granted permission for HRLN lawyers to visit the shelters and observe their condition.

## Orders

### September 1, 2010

The present writ petition was initiated suo motu by this Court on the basis of a newspaper report dated 29th August, 2010 published in Hindustan Times that a destitute woman, on a busy street, died giving birth to a baby girl, namely, Karishma who is struggling for her life at a foster home, namely, "Udayan". The newspaper highlighted the suffering of the destitute mother and the welfare of the child and the guidelines for getting the child adopted… We have been apprised that after the child was born, Ms. Ritu Arthur

Fredrik had saved the child as she was suffering from septicemia but thereafter the police took the child in its custody and gave it in custody to the children home.

We have been told by both the doctors that the child has improved and septicemia has been cured. Though the doctors have said that the child has been cured, yet we inquired from them whether certain tests have been conducted or are required to be conducted. The doctors, namely, Dr. Renu Trehan and Dr.Harish Pandey submitted with all fairness that a periodical check up is necessary as the child had suffered from septicemia, though a milder one. Both the doctors agreed that there has to be a blood profile which would include the LFT test, and an x-ray to find out that there are no breathing spots or any patches in the lungs. That apart, the platelet count should be done along with other necessary tests as thought apposite by the doctors.

At this juncture, the brother and sister-in-law of Ms. Ritu Arthur Fredrik submitted that Ms. Ritu Arthur Fredrik should be allowed to adopt the child as she had saved the life of the child at the initial stage. Mrs.Raina has serious opposition on the ground that there is a set of guidelines of "Udayan" and the child cannot be given on adoption as claimed. Without entering into the said debate at this juncture, we would only like to direct that the child shall stay at "Udayan" in the care of the authorities of "Udayan" and Ms. Ritu Arthur Fredrik shall have the right to visit the child thrice a week, namely, Tuesday, Thursday and Saturday between 10 am to 01 pm for a period of 45 minutes. Be it noted, Ms.Ritu Arthur Fredrik shall go alone to visit the child and no one shall be allowed to accompany her. Be it further noted, the issue of giving the child on adoption shall be considered at a later stage.

Presently, we shall advert to the issue which lies in a broader spectrum. We have been apprised that there are many hospitals run by the State Government who do not admit pregnant women as a consequence of which they are compelled to give birth on the footpath. If there has been any kind of tragic situation, the present one enormously so projects. We have been apprised that there are number of schemes, namely, Janani Suraksha Yojana (JSY), Integrated Child Develop Scheme (ICDS), The National Maternity Benefit Scheme (NMBS), the Antyodaya Yojana, National Family Benefit Scheme (NFBS), etc. When such a host of schemes are in vogue, it is really perplexing that children of this country have to breathe the first breath on the road side footpaths.
…
…[I]t is the sacrosanct duty of the State Government to see that the children are looked after within the guidelines and schemes framed and the Government hospitals and the hospitals which have taken benefit from the State Government, wherever situated, do not deny a pregnant woman entry to give birth to [her] child. … The emphasis

has to be laid on mother care and should not be allowed to suffer or take a back seat despite so many measures taken by framing of the schemes. Be it noted, a learned Single Judge of this Court in WP(C) No. 8853/2008 (Laxmi Mandal v. Deen Dayal Harinagar Hospital and Ors.) had given a number of directions pertaining to almost a similar subject. However, we would like the State Government to file a counter affidavit highlighting how the said disturbing feature is totally nullified. We have said so as we are disposed to think that such a feature should not occur in a civilized society and there has to be a perceptual shift in this regard. To have the assistance in this case, we appoint Mr. Colin Gonsalves, learned Sr. Advocate as the Amicus Curiae.

**October 20, 2010**

Heard Mr. Colin Gonsalves, learned Amicus Curiae and Mr. Najmi Waziri, learned standing counsel for Government of NCT of Delhi. This Court on 1st September, 2010 …had issued certain directions related to the factum of adoption by Ms. Ritu Arthur Fredrick who had saved the life of baby girl. It is submitted by Mr. Najmi Waziri that the process of adoption of the child has been undertaken but at this juncture it is difficult to state whether the child can be given on adoption to Ms. Ritu Arthur Fredrick or not.

At this stage, we do not intend to say anything on that score, however, we direct before final steps are taken in the matter of adoption, leave shall be obtained from this Court. We have been further apprised by Mr. Waziri that the child is in a healthy condition. We appreciably note the same. …

In the course of hearing, after taking note of the fact situation, we thought it apposite to give certain suggestions to the Government of NCT of Delhi to explore the possibility to carry out the same. …:

(1) Government of NCT of Delhi to demarcate five secured shelter homes exclusively meant for destitute women, pregnant and lactating women so that apposite care can be taken and no destitute women would be compelled to give birth on the footpath.

(2) The availability of the facilities in such shelter homes shall be monitored by the helplines handled by professionally trained people.

(3) In the aforesaid shelter homes, food and medical facility shall be available for 24 hours as such facilities are imperative for the cases of the present nature.

(4) Despite various schemes being framed by the State Government, as the people are not aware of the same, especially due to illiteracy, there would be dissemination of information by radio as well as television in Hindi.

(5) There should be awareness camps in the areas or cluster of areas by professionally trained people every fortnight.

(6) The State Government shall provide a mobile medical unit so that the people, especially who are living in slum areas can be taken to the shelter homes or to the hospital as the case may be.

(7) The State Government shall make endeavour to involve the genuine NGOs so that they can also work for getting the scheme fortified as such an activity has to flow from the top to the ground reality level.

**January 12, 2011**

…
On 20th October, 2010, after hearing Mr. Colin Gonsalves, learned Amicus Curiae along with Ms.Jayshree Satpute, Advocate, this Court had issued the following directions: [See the 7 suggestions listed in the previous order above]-

Thereafter, when the matter was listed, Mr.Jayant Bhushan, learned senior counsel was requested to assist the court and to give certain suggestions. In pursuance of our earlier orders, a counter affidavit has been filed by the Government of NCT of Delhi. In the counter affidavit…the stand and stance of the State is that there are various homes which are meant to take care of destitute and pregnant woman as well as the lactating woman. Ms.Satpute has submitted a written note of submission especially referring to the seven shelter homes which are available to the destitute, deserted women and girls who are in need of immediate protection or are in moral danger. As is evincible from the written note of submission, the learned Amicus Curiae has contacted Jivodaya Ashralayam: Care and Rehabilitation Centre for destitute women, Santidham, a home for destitute women care and rehabilitation centre for destitute women, Shri Digambar Jain Mahila Ashram, Missionaries of Charity Shelter for unwed mothers.

On a perusal of the submissions, it is perceptible that the said rehabilitation centres for destitute women and care homes are not funded by the State Government and they have categorically stated that they do not intend to provide care and service for pregnant and lactating women in future as it is beyond their functioning capacity. It is also discernible that the Missionaries of Charity are only devoted for unwed mothers

and also availed the government funds. That apart, it is evident that the shelter has capacity to service only 20 unwed pregnant women with medical, nutritional and social services. Thus, what has been stated in the counter affidavit really does not take care of the situation obtaining in the ground reality.

Be it noted, in the counter affidavit there is reference to a family counselling Unit helping victims of rape, Rape crisis cell, Mobile van helpline, Mahila Panchayat Programme, Pre-Marital Counselling Cell, Awareness campaigns, Scheme for implementing the protection of women from Domestic Violence Act, Scheme for working women's hostel, Scheme of short stay home for women in distress, children homes for the care and protection of destitute children, Mental health unit at Nirmal Chhaya Complex and Campaign to make Delhi free of violence against women and girls. ...

"9. It is also respectfully submitted that every year, there is large influx of poor migrants from neighbouring states to Delhi. These people come from the lowest strata of society. The medical facilities available in the state of origin is extremely poor and inadequate. The Delhi Government is making efforts to cater to the increasing demand of medical and rehabilitation care for this large continuously migrating population.

10. It would however be appropriate if Union Government is requested to issue suitable directive to the neighbouring states to provide adequate infrastructure facilities for destitute women, pregnant and lactating women belonging to the deprived sections of society. Further, due to limited availability of land in the national capital, it may be difficult to set up large capacity shelters exclusively for this target group in Delhi. Large tracts of land are available in neighbouring states to set up high capacity shelter homes which can take care of this target group. These centres can be run by reputed NGOs and financial assistance can be provided by the Union Government or respective State Governments."

It does not require solomon's wisdom to say that the affidavit nowhere really focuses on the problem that has crept up. Mr. Jayant Bhushan, learned senior counsel, who was requested to give certain suggestions, submitted that he has not drafted out any suggestion as nothing has been done by the Delhi Government regard being had to the directions given by this Court on earlier occasion…

At this juncture, Mr. N. Waziri, learned standing counsel appearing for the Government of NCT of Delhi submitted that the homes that the learned Amicus Curiae has visited may not reflect the correct picture but, as advised at present, we are not inclined to accept the said submission of the learned standing counsel for the State. Mr.Atul Nanda, learned standing counsel for the Union of India submitted that Joint Secretary,

Ministry of Women and Child may be give the responsibility to coordinate with the State Government as well as the Municipal Corporation of Delhi to find out about the homes, which the learned Amicus Curiae has visited, whether they are really funded by the Government and what activities they are taking.

Though we are inclined to direct that the said exercise be done, yet we just cannot become the silent spectators waiting for the Government to move like a tortoise and allow the destitute pregnant women and lactating women to die on the streets of Delhi, maybe after giving birth to a child or maybe along with the child. Such a situation cannot be countenanced… in the backdrop of Article 21 of the Constitution of India. …In view of the aforesaid, we command the Government of NCT of Delhi to file a proper and comprehensive affidavit within a period of four weeks and pending that we direct the Government of NCT of Delhi to demarcate or hire or create at least two shelter centres meant for destitute pregnant women and lactating women so that proper care can be taken to see that no destitute woman is compelled to give birth to a child on the footpath. We are sure, no apathy shall be shown in this regard as any kind of recalcitratant, propensity or proclivity in this regard would be violative of the concept of Rule of Law.

At this juncture, we may note with profit one of the suggestions given by Mr. Jayant Bhushan. It is submitted by Mr. Bhushan, learned senior counsel that when the State takes recourse to such an action, it should be widely published so that the people who are in such a situation or the people who are aware of such a situation and can help people and also can take them to such shelter homes. We are sure, the State Government shall live upto the same and do the needful within a week including spreading of awareness as stated hereinabove. Needless to say, a shelter home should have facility for food and appropriate medical aid.

…

**January 19, 2011**

…

This court on 12th January, 2011 while adverting to many a facet had directed as follows:

"In view of the aforesaid, we command the government of NCT of Delhi to file a proper and comprehensive affidavit within a period of four weeks and pending that we direct the Government of NCT of Delhi to demarcate or hire or create at least two shelter centres meant for destitute pregnant women and lactating women so that proper care can be taken to see that no destitute woman is compelled to give birth to a child on the footpath."

In pursuance, only the said aspect was directed to be adverted today. Mr. N.Waziri, learned standing counsel for the GNCTD, has filed a communication issued by the Joint Director (WEC) wherein two locations… have been identified. It is put forth in the said communication that the said two identified shelter centres have been physically inspected by officials of the department of Women and Child Development and further Delhi Urban Shelter Improvement Board has agreed that while the infrastructural facilities at the above mentioned shelter centres would be provided by it, the management of these specialized centres would be looked after by the department of Women and Child Development.

It is worth noting, in paragraph 7 of the communication it has been stated as follows:

> "The Department has also identified two organizations, namely Delhi Young Women's Christian Association (YWCA) and All India Women's Conference (AIWC), from whom proposals have been invited to set up and run these shelters. Both these organizations have sufficient experience of working with women in difficult circumstances."

It is submitted by Mr.Jayant Bhushan, learned amicus curiae and Ms.Jaishree Satpute, learned counsel for the petitioner, that the State Government has possibly harbored the idea to wash its hands from providing the shelter homes and that is why it has thought of two organizations to run the said centres.

Mr.N.Waziri, learned standing counsel for the GNCTD, would submit that the State Government is sanguine in establishing the shelter homes throughout Delhi and as per the previous order has identified these two centres and regard being had to the delicate nature of the issue these two experienced organizations have been given the responsibility and they have agreed in principle.

Whether the shelter homes are directly run by the State or by the two organizations may not be a debate for the present but the purpose is that the destitute pregnant women and lactating women get shelter and do not give birth to child as if it is unwanted. Further, as the communication would show, the State Government intends to have control over the said shelter homes and accordingly we direct that even if the State Government would appoint any agency to run the aforesaid two shelter homes, there shall be coordinators/supervisors in each of the two places so that someone can be made accountable. Let this exercise be completed within two weeks from today.

Ms.Jaishree Satpute, learned counsel for the petitioner, is at liberty to visit the shelter homes and submit a report. As further aceeded to she shall not put any questions to

anyone or behave like an investigator but only see what is going on and report to this court.

…

**February 9, 2011**

In pursuance of the aforesaid order, an affidavit has been filed by the GNCT Delhi, stating, inter alia, that two shelter homes one at Jahangir Puri and the other one near Sarai Rohilla Police Station have been established.

Ms. Jaishree Satpute submitted that she had visited the …shelter home at Jahangir Puri, meant for the destitute pregnant and lactated women but the same is far away from the homeless hub… [meaning] areas situated in Central Delhi, i.e., Connaught Place, Jama Masjid, Nizzamuddin Railway Station, Old Delhi, Karol Bagh, Kalkaji, Paharganj, etc. Mr.N.Waziri, learned counsel for the State, disputed the same.

At this juncture, without entering into the said debate at present, we would command the State Government to make two Ambulance vans available for the utilization of the shelter homes each at Jahangir Puri and Sarai Rohilla so that Ms.Satpute, Mr.Indu Prakash Singh, Dr.Amod Kumar from Mother NGO, can contact with Ms.Renu Love, Assistant Director, Women and Child Development, and also the person in-charge of the shelter homes, so that the vans can immediately be sent to pick the destitute and lactated women so that they can avail the facility of the shelter homes. Ms.Satpute fairly stated that she will provide the mobile phone numbers of the persons who have voluntarily agreed to communicate with the officers concerned and the person in-charge, so that the members can be identified and immediate steps can be taken.

It is further contended by Ms.Satpute that she has not visited the second home. It is urged by her that she will visit the second home within two weeks and file a report and also indicate as to how many destitute pregnant and lactated women have been taken to the first shelter home so that this Court can think of passing appropriate orders in respect of the homes in the next hearing.

…

**March 23, 2011**

Heard Mr. Jayant Bhushan, learned Amicus Curiae, Ms. Jayshree Satpute and Mr. Najmi Waziri, learned Standing Counsel for the GNCTD. Mr. Waziri has filed a set of guidelines, viz., draft guidelines for running the shelter homes for destitute pregnant and lactating women. The same has been served on Mr. Bhushan and Ms. Satpute. It is

worth noting that Ms. Satpute has filed the status report and in the said report she has given certain suggestions. Mr. Bhushan, in course of hearing of this petition, has given the following suggestions:

(a) The period of stay of the pregnant or lactated mother should not be a restricted to six months/one year and if eventually if she is found to be homeless and economically totally downtrodden, shelter homes for such category of women should be established and some kind of vocational training should be imparted to them so that they would be in a position to earn livelihood.

(b) The draft guidelines indicate that a child above six years would be separated from the mother as they are not allowed to stay with the mother admitted to the shelter home. It is submitted that is very difficult to accept that a 7/8 year old child should be separated from the mother at that stage and, therefore, the State has to appropriately think and come with a more holistic policy/guidelines.

(c) The children when they are separated from their mothers should be sent to child care homes instead of any other place so that the child shall stay in a more amiable and friendly atmosphere developing social values.

(d) The State Government may consider having shelter homes in more centralized locations so that women in need have easy and immediate access.

(e) The awareness campaign and dissemination of information should be more accentuated so that the people would know about the shelter homes and the facilities available therein.

2. Mr. Waziri, learned Standing Counsel shall discuss with the competent authorities of the State Government and file a comprehensive policy keeping in view the suggestions given by Mr. Jayant Bhushan, learned senior counsel and Ms. Satupte, whose suggestions we have recorded hereinabove.

3. Having regard to the suggestions given by Ms. Satpute and Mr. Bhushan, one thing strikes that children who are juvenile and belong to economically weaker and marginalized section of the society due to various reasons sometimes take drugs and, therefore, the GNCTD must establish de-addiction centres which should be fully equipped. Be it noted, a de-addiction centre is coming up in the juvenile home at Sewa Kutir. All efforts shall be made to make it functional within a week hence. … Mr. Nigam has fairly stated that he will visit the de-addiction centre immediately and thereafter as and when required and a progress report shall be placed before this Court.

…

# Deepika D'Souza v. Municipal Corporation of Greater Mumbai & Ors., High Court of Bombay PIL 127/2009

## Synopsis

This case is one of many in which a destitute pregnant woman was denied health care and welfare benefits under the JSY, NRHM, and other schemes. Having been denied health care, the woman was forced to deliver her child in public. The pending case illustrates the systematic nature of the denial of pregnant women's rights to health and a dignified life.

### Facts

In January 2009, Aariya Khan was denied emergency obstetric services from two medical clinics. As a result, she delivered her child on a train platform. HRLN filed a public interest petition seeking compensation on her behalf. In addition, the petition seeks implementation of health care schemes to make sure that other poor and homeless women do not face the same denial of their rights to health and life.

### Relevant Law

*Constitution*: Article 21 (right to a dignified life)
*Statutes & Schemes*: JSY

## Outcome

As of this book's writing, the case is still pending. However, the Court has directed the government to show cause as to why compensation should not be granted.

## Orders

### February 4, 2010

The Petitioner seeks to espouse the case of poor pregnant women who require assistance at the stage of delivery. ... The learned counsel takes an exception to Para 3(b) whereby it is set out that as per the guidelines of "Janani Suraksha Yojana" an amount of Rs. 600/- is given to the mother for institutional delivery and that the benefits are given for first two deliveries only. On behalf of the Corporation it is pointed out that this is in terms of the policy itself.

There are other issues to be considered in view of the fact that Respondent Nos. 5 and 6 yet to file their reply. Appearance put on behalf of Respondent No. 2. Issue fresh notice to Respondent No. 3 made returnable after three weeks.

## August 5, 2010

…. Respondent Nos.1 to 5 to show cause why the mandatory interim relief prayed for in prayer clause h(ii) should not be granted. Respondent No.4 shall place on record all the relevant medical records of Aariya Khan and her child who were admitted in the hospital on 29th January, 2009.

# Dunabai v. State of Madhya Pradesh & Ors., High Court of Madhya Pradesh at Indore W.P. 5097/2011

## Synopsis

The *Dunabai* case focuses on the denial of maternal health care to poor women, especially members of Scheduled Tribes, in the Barwani District of Madhya Pradesh. Discrimination against tribal women and violations of their rights to health and life are major contributing factors to Madhya Pradesh's shockingly high MMR.

### Facts

In Barwani District, Madhya Pradesh, many poor rural women continue to die or suffer serious injury from preventable pregnancy-related causes. Because of government negligence in the provision of health services, at least 25 women died due to the lack of emergency obstetric care between April and November 2010 in Barwani alone. Inadequate infrastructure and discrimination against tribal women make access to health care impossible in Barwani District. Accordingly, many women deliver at home or in public after being rejected from public health facilities.

### Relevant Law

*Constitution*: Articles 14 (right to equal protection), 15 (right to be free from discrimination), & 21 (right to a dignified life)
*Case Law*: *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others,* W.P. (C) 8853/2008; *Jaitun v. Maternal Home MCD, Jangpura & Others,* W.P. (C) 10700/2009 (holding that women have the right to survive pregnancy and childbirth)
*Statutes & Schemes*: JSY, NRHM

## Outcome

In an interim order, the High Court of Madhya Pradesh directed the state to formulate a plan of action to combat maternal death and provide appropriate health care services in the rural areas. The Court specified that the plan should be detailed and time bound. The case is still pending.

## Orders

### May 15, 2012

…
Basic grievance in this Public Interest Litigation is the high mortality rate of mothers during or shortly after child birth in the area known as District Barwani.

It would appear that even without the orders of the Court, when such allegations are made, it would be obligatory on the part of the State Government to conduct a systematic survey in that area about such issues, and to find out the causes for such mortality, and then to take remedial measures, keeping the causes in mind. The remedial measures may include having hospitals or health services equipped with the bare minimum medical equipments and the essential medicines (in the light of the causes found) along with the necessary medical and paramedical supporting staff. Further in case having regard to the nature of the terrain of part of the area in question, there is difficulty of commuting between some remote places and the health centres, necessary arrangements of ambulances for commuting of the patients expeditiously and in a safe manner, would also be required to be undertaken. Thereafter, it would be necessary from time to time to monitor the number of pregnancy/child-birth cases which the establishment and staff has handled, and if number of patients is less, to determine the causes for the same and take remedial measures.

From these angles a plan of action may be prepared by the State Government, if not already prepared, and given supplementary status report. It is also made clear that the aforesaid plan of action should be time bound and not vague.
…

# Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors., Delhi High Court, W.P. 8853/2008, *joined with* Jaitun v. Maternity Home MCD, Jangpura & Ors., Delhi High Court, W.P. 10700/2009

## Synopsis

This petition outlined serious violations of the right to reproductive health, the right to food, and the right to a dignified life. Two women, Shanti Devi and Fatima, suffered enormous injury due to the government's sustained failure to provide appropriate pre-natal, delivery, and post-natal care. Shanti Devi ultimately perished from her injuries and Fatima delivered her child under a tree in full public view. In a landmark decision, the Court held that women have the right to survive pregnancy and childbirth, meaning that the government is obligated to provide health services and other welfare benefits such that no woman suffers death or disability from preventable pregnancy and childbirth related causes.

### Facts

*Laxmi Mandal v. Deen Dayal Harinagar Hospital*

The state initially denied Shanti Devi adequate maternal health care during her fifth pregnancy. Local authorities in charge of pre-natal health failed to register her pregnancy and treat her for anemia. Later, after falling down the stairs, Shanti Devi sought treatment at a nearby government hospital. There, she was negligently treated and referred without explanation to another institution. Ultimately, she was forced to carry a dead foetus for five days before public health workers would treat her.

Even after HRLN's intervention in this incident, Shanti Devi was not given proper counseling about reproductive health and birth control, as another pregnancy could endanger her life. Moreover, she was never treated for anemia. Ultimately, Shanti Devi became pregnant for a sixth time and died of hemorrhage after giving birth prematurely. Shanti Devi's child survived.

*Jaitun v. Maternity Home, MCD, Jangpura, & Ors.*

On May 29, 2009, Fatima, an illiterate woman abandoned by her husband, was forced to deliver her child under a tree in full public view. Fatima was suffering serious epileptic fits and has no access to skilled health care or medical guidance. Local authorities

in charge of providing pre-natal care had not registered Fatima's pregnancy, and thus she was denied the entitlements set under the National Rural Health Mission (NRHM) 2005–2012 and Integrated Child Development Scheme (ICDS).

An investigation also highlighted the corrupt actions of the Maternity Home, MCD situated at Jangpura. For example, in order to escape accountability for failing to care for Fatima and her child, the Maternity Home falsely recorded that Fatima gave birth at their institution.

### Relevant Law

*Constitution*: Article 21 (right to a dignified life)
*Cases*: *Paschim Bengal Khet Mazdoor Samity & Ors. v. State of West Bengal & Anr., AIR 1996 SC 2426* (the right to health is part of the right to life guaranteed by Article 21); *People's Union for Civil Liberties (PUCL) v. Union of India, Supreme Court W.P. (C) 196/2001* (underscoring the intersection between welfare schemes, including ICDS and NMBS, in securing the rights to food and health which are essential for the right to a dignified life)
*Statutes & Schemes*: AAY, ICDS, JSY, NMBS, NRHM; Protection of Human Rights Act, 1993 (PHRA) (binding India to treaties it has ratified insofar as they are not inconsistent with domestic law)

*International Law*: Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) Articles 12 (States Parties should endeavor to prevent discrimination against women) & 14 (States Parties should undertake to address the needs of rural women, especially in health care); ICESCR Articles 10 (States Parties should make special provisions for childbirth and motherhood) & 12 (everyone has the right to the highest attainable standard of physical and mental health); Universal Declaration of Human Rights Article 25 (declaring that all individuals have the right to food, health, and an adequate standard of living; in particular, "[m]otherhood and childhood are entitled to special care and assistance")

## Outcome

In its interim orders, the Court directed the government to provide appropriate care to Fatima and her child and to Shanti Devi's baby. Throughout the case, the Court was vigilant in ensuring that relevant officials followed up with necessary medical care and compensation under various welfare schemes, including JSY and NMBS. Furthermore, the Court ordered a maternal death audit to determine the situation surrounding Shanti Devi's death.

In its final ground breaking judgment, the Court ordered substantial compensation to Fatima and her child, and to Shanti Devi's family. Most importantly, the Court noted the systematic failure in implementation of government schemes for poor women and children. The Court emphasized that these schemes must be made effective and must work in unison to protect the rights of pregnant and lactating women and their children to food, health and life. According to the Court, the right to food is particularly essential for pregnant women and their infants. The Court stated that a denial of food amounts to a denial of the right to life. With this landmark judgment, the Delhi High Court became the first court in the world to hold that women have the right to survive pregnancy and childbirth, and directed the government to fulfill its obligations in this regard.

## Orders

### Jaitun

### August 6, 2009

It is stated that Ms. Fatima is not in a position to move and requires immediate medical treatment and attention. The MCD will provide or arrange for an ambulance for shifting Ms. Fatima and the baby to MCD maternity home. MCD shall also provide her necessary treatment as per rules or get Ms. Fatima admitted in a hospital where proper medication and treatment can be provided. MCD maternity home shall state whether any immunization has been given to the baby and card/prescription in this regard will be issued. Ms. Fatima will be entitled to take assistance of social workers, who are helping her. …

### December 11, 2009

1. Learned senior counsel appearing for the petitioner states that the petitioner is entitled to following benefits:-
   (I) Card under the Antyodaya Anna Yojana.
   (II) Benefits under the Integrated Child Development Scheme in terms of order dated 28th November, 2001, passed by the Supreme Court in W.P.(C) 196/2001
   (III) Cash benefit of Rs.500/- under the National Maternity Benefit Scheme.

2. Counsel for the respondent, Government of NCT of Delhi will within a period of three working days furnish to the counsel for the petitioner relevant forms for

supply of rations under the Antyodaya Anna Yojana. The petitioner with the help of her counsel will fill up the form and submit the same in the relevant office. Counsel for the respondent, Government of NCT of Delhi will ensure that the form is processed expeditiously and the relevant card is issued after completion of formalities within one week from the date form is submitted.

3. Counsel for the petitioner submits that the petitioner wants to be attached with Aaganwadi centre, Jangpura for availing the benefits under the Integrated Child Development Scheme. Counsel for the respondent, Government of NCT of Delhi will ensure that petitioner is granted benefits of the said scheme at Aaganwadi centre, Jangpura, immediately.

4. Counsel for the respondent, Government of NCT will obtain instructions on payment of cash benefit of Rs. 5,00/- under the National Maternity Benefit Scheme.

5. In the additional affidavit filed by the petitioner, it is stated that the Ms. Fatima has been suffering from epileptic seizures. Ms. Fatima will visit the Neurology Department of G.B. Pant Hospital today at 2.30 P.M. Counsel for the respondent, Government of NCT of Delhi will inform the concerned authorities. It is also open to Ms. Fatima to visit the MCD dispensary in case of emergency or for any other medical aid. If required, the MCD will arrange for ambulance. …

**January 8, 2010**

1. Among the grievances still outstanding are that the Petitioner' daughter Mrs.Fatma has not yet been given the Antyodaya Anna Yojana ("AAY") card. Today the said card has been brought to the Court by Ms. Usha Rani (Lady Health Visitor) of the Municipal Corporation of Delhi ("MCD"). It is stated that the said card had been taken for stamping on it the name of the ration shop from which the allocation can be availed of by Mrs. Fatma. It is assured by Ms. Zubeda Begum, learned counsel appearing for the GNCTD that she will issue necessary instructions to ensure that if Mrs. Fatma approaches the ration shop named in the AAY card on 11th January 2010, she will be given her entitlement of grain.

2. The next aspect is about the medical assistance that Mrs. Fatma requires for herself and her child. It is stated that her breast milk stopped immediately after delivery and has not recommenced due to malnutrition. Although she underwent a check-up in the department of Neurology of G.B.Pant Hospital earlier, she could not visit the said hospital again since no ambulance was provided to her. It is stated by Ms. Usha Rani that Mrs. Fatma along with the social workers can report to the Maternity

Home, MCD, Jangpura at 10 am on 12th January 2010 and every arrangement will be made to ensure that Mrs. Fatma and her child get appropriate medical assistance on 12th January 2010 itself. If so warranted, an ambulance will be arranged for Ms. Fatma to be taken to the G.B.Pant Hospital for further check-up and treatment.

3. It is directed that a compliance report on both the aspects referred to herein before will be filed in Court by the next date of hearing by the MCD and the GNCTD respectively.

4. Mr. Baldev Malik, learned counsel appearing for the Union of India states that the concerned department of the GNCTD will be given instructions to the effect that the cash benefit of Rs.500/- payable under the National Maternity Benefit Scheme ("NMBS") will be paid forthwith to Mrs. Fatma by the next date of hearing. It is made clear that if this benefit of Rs.500/- is not paid to Mrs. Fatma by the next date of hearing, the Health Secretary of the GNCTD as well as the concerned Joint Secretary of the Ministry of Health, Union of India who is supposed to coordinate with the State Governments as regards the NMBS will remain personally present in Court on the next date of hearing. …

## Joined Laxmi Mandal/Jaitun

### March 3, 2010

1. This is an application for an order to permit Dr. M. Prakasamma, currently working as Director, Academy for Nursing Studies and Women's Empowerment Research Studies, at Hyderabad to conduct "maternal audit" with respect to the death of Shanti Devi.

2. Notice had been issued in this application on 11th February 2010. Ms. Mathur, learned counsel for the Respondent GNCTD informs this Court that the CNBC may not have a specialist who can undertake a maternal audit. She states that it is possible that some other government hospital may have competent medical professionals who can do so.

3. Mr. Gonsalves, learned Senior counsel for the Petitioner stats that Dr. Prakasamma is not expecting to be compensated for sparing her time for conducting the maternal audit. He states that the NGO who has supported the Petitioner will take care the expenses, including travel and stay, of Dr. Prakasamma, the curriculum vitae of Dr. Prakasamma is placed on record.

4. In the circumstances, this Court directs that Dr. M. Prakasamma will be permitted to undertake the maternal audit with regard to the death of Shanti Devi and all matters incidental thereto. The remit of Dr. M. Prakasamma will include examining the circumstances under which initially Shanti Devi, when she was admitted to the Sanjay Gandhi Hospital on 19th November 2008, was found to be carrying a dead baby foetus and the events subsequent thereto. She will be permitted to visit and inspect the records of the Deen Dayal Harinagar Hospital, New Delhi, Sanjay Gandhi Hospital, Mangol Puri, Saroj Hospital, Sector-14, Rohini, Badsha Khan General Hospital, Faridabad and the First Referral Unit I.R.C. Hospital, Faridabad. In addition, she will also be given access to the records of the CNBC. In each of the above institutions, she is permitted to meet the doctors who undertook the treatment of Shanti Devi and/or the baby.

   …

7. The broad issues in these petitions are concerned the reproductive rights of health as well as the rights of the newly born to free treatment and care in government medical facilities essentially on the ground that they are persons below the poverty line. From what has transpired in these cases thus far it is plain that there are some schemes formulated by both the Government of the National Capital Territory of Delhi ("GNCTD") as well as the Central Government to address the issues. However, there appear to be no operational guidelines issued that can actually facilitate the accessing of free medical care by expectant mothers and the newly born babies, belonging to the below poverty line category.

8. The GNCTD and the Union of India ("UOI") are parties to these petitions. Each of them seeks some more time to have a joint consultation to bring out a set of instructions which can ensure that free treatment and care is available to expectant mothers and babies in all government medical facilities in Delhi. These petitions also raise a larger question as to the availability of free treatment and care anywhere in the country where these persons may be compelled to move due to some reason or the other. In other words, the UOI will have to come out with a set of instructions, in coordination with the GNCTD in the instant case, to ensure that the entitlements to free medical treatment and care of persons below poverty line is not denied merely on account of their having to move away from their place of ordinary residence. The above aspects should be specifically dealt with in the additional affidavits to be filed by the GNCTD and UOI in these cases by 5th April 2010.

   …

**May 24, 2010**

1. Despite specific direction given to Mr. Kaliappan, Under Secretary, Ministry of Health, Union of India during the hearing of this case in the forenoon that he should contact the Health Secretaries of the GNCTD as well as State of Haryana over telephone to fix up meetings to ascertain the status implementation in the two States of various schemes of the Central Government including the Antyodaya Anna Yojana Scheme, the Integrated Child Development Scheme (ICDS), the National Family Benefit Scheme, and the National Maternity Benefit Scheme (NMBS), Mr. Kaliappan informs the Court that it is only Mr. Amit Mohan Prasad, the Joint Secretary in the Ministry of Health, who can undertake this exercise and that he needs some time.

2. The Court finds this response to be wholly unacceptable since this is a part-heard matter and there was sufficient time already granted to the Respondents to meaningfully respond to the Court on the submissions already made at great length by the learned counsel for the Petitioners on the last two hearings.

3. Mr. Amit Mohan Prasad, Joint Secretary, Ministry of Health, Government of India is directed to personally remain present in this Court tomorrow at 2.15 pm. The Registrar General of this Court is directed to telephonically contact and also fax a copy of this Order to the Health Secretaries of both the GNCTD as well as the State of Haryana who will either themselves be personally present or depute a senior level officer, conversant with the above schemes to remain personally present in the court at 2.15 pm tomorrow.

…

**May 25, 2010**

1. Pursuant to the order passed yesterday, Mr. Amit Mohan Prasad, Joint Secretary, Ministry of Health, Govt. of India, Dr. Jayadev Sarangi, Special Secretary (Health), Government of the National Capital Territory of Delhi (GNCTD), Dr. Parveen Garg, Chief Medical Officer (CMO), Gurgaon and other senior personnel from the Departments of Family Welfare, Women and Child Development, Reproductive and Child Health are present in Court. The Court has required them to respond to the following specific questions which in the opinion of the Court arise for consideration on the pleadings as well as submissions made by Mr. Colin Gonsalves, learned Senior counsel and Mr. Divya Jyoti Jaipuriar, learned counsel for the Petitioners:

    1. What is the status of implementation of the order passed by the Supreme Court on 20th November 2007 in the case of PUCL v. Union of India

concerning the Janani Suraksha Yojana and National Maternity Benefit Scheme? How was the order implemented in these two cases?\

2. What is the status of implementation of the orders passed by the Supreme Court on 13th December 2006 and 22nd April 2009 in the case of PUCL v. Union of India concerning the ICDS? How were the orders implemented in these two cases?

3. What is the status of implementation of the order dated 9th July 2007 of the Supreme Court in the case of PUCL v. Union of India concerning Anganwadi centres? How was the order implemented in these two cases?

4. Which are the Supreme Court orders relevant to these schemes and the two cases? What is the status of implementation of these orders in Delhi and Haryana?

5. In particular, what is the staffing pattern district wise with particular reference to these two cases? Did the persons deployed for implementation i.e. [ASHA, Auxillary Nurse Midwife (ANM), medical and paramedicals, etc.] extend the necessary assistance in these two cases?

6. What is the audit mechanism put in place by the central government for assessing the effectiveness and implementation of each of the schemes?

7. How do the schemes and their working, ensure that the beneficiaries get access to benefits under the schemes on a continuous basis?
8. How are babies/children/infants who have a single parent or no parent or who have parents who are migrating, assured of continuous assistance under these schemes?\

9. With particular reference to migrant population, how is continuous access to benefits under the scheme assured, irrespective of where the person moves?

10. What specific directions do the Ministry of Health and other Departments in the Government of India, the Government of Delhi and Government of Haryana require from the Court to strengthen the working of the schemes?

11. How do homeless people or people on street gain access to these schemes?

2. Mr. Amit Mohan Prasad states that he will convene a meeting of the Special Secretary, GNCTD, the Director of Health Services, GNCTD, the CMO, Gurgaon and senior

personnel of other concerned departments, some of whom are present in Court today, to discuss the above questions and give a response on the next date.

3. Mr. Colin Gonsalves, learned Senior counsel for the Petitioner has handed over a note in each case of the reliefs that have been granted and those that remain to be granted. They are taken on record. Copies have been furnished to the learned counsel for the other parties.
…

## Judgment

**Delhi High Court. June 4, 2010**

## Introduction

1. These two petitions highlight the deficiencies in the implementation of a cluster of schemes, funded by the Government of India, which are meant to reduce infant and maternal mortality. The issues common to both petitions concern the systemic failure resulting in denial of benefits to two mothers below the poverty line (BPL) … under the Janani Suraksha Yojana ("JSY"), the Integrated Child Development Scheme ("ICDS"), the National Maternity Benefit Scheme ("NMBS"), the Antyodaya Anna Yojana ("AAY") and the National Family Benefit Scheme ("NFBS"). Although the interrelatedness of these schemes was recognised 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 these two cases reveal.

2. …These petitions are essentially about the protection and enforcement of the basic, fundamental and human right to life under Article 21 of the Constitution. These petitions 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.
A brief synopsis of the Schemes

## The JSY

…

7. One feature of the JSY is that only a woman, more than 19 years of age who is BPL can be a beneficiary in High Performing States ("HPS"). In case a poor woman does not have a BPL card then the beneficiary can access the benefit upon certification by Gram Panchayat or Pradhan provided the delivery takes place in a government institution. Cash assistance in HPS is limited to two live births. ... The JSY identifies only 10 states as low performing states ("LPS") and the remaining as high performing states ("HPS"). What is to be borne is mind however is that the cash incentive is but one component of the JSY.

8. The NCT of Delhi and Haryana have not been named as LPS. Nevertheless, the figures of utilisation of the funds allocated under the JSY for 2006-07, as well as the percentage of home deliveries as recorded by the Supreme Court in order dated 20th November 2007 have a different story to tell. The percentage of home delivery figures in Haryana for 2006-07 was 61%. This means that the institutional delivery was as low as 39%. The utilization of the funds allocated by the JSY for Haryana also showed a low utilization percentage of 11.2%.

## The NMBS

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

10. At this juncture it must be noted that in para 15 of its order dated 20th November 2007, the Supreme Court observed as under: "15. At this juncture it would be necessary to take note of certain connected issues which have relevance, it seems from the scheme that irrespective of number of children, the beneficiaries are given the benefit. This in a way goes against the concept of family planning which

is intended to curb the population growth. Further the age of the mother is a relevant factor because women below a particular age are prohibited from legally getting married. The Union of India shall consider this aspect while considering the desirability of the continuation of the scheme in the present form. After considering the aforesaid aspects and if need be, necessary amendments may be made."

11. It appears that consequent upon the above observation, the Union of India filed an application in the Supreme Court seeking certain modifications to the above order. However, no orders as yet have been passed in that application. The present position therefore is that the above order dated 20th November 2007 of the Supreme Court holds the field and is required to be strictly implemented by all the States and UTs.

## The ICDS

…

14. The working of the ICDS has been examined by the Supreme Court and several orders have been passed by it. In its order dated 29th April 2004, the Supreme Court noted that the implementation was "dismal" and that "...a lot more deserves to be done in the field to ensure that nutritious food reaches those who are undernourished or malnourished or others covered under the scheme." The Court observed that according to the Government of India norms, an Anganwadi Centre (AWC) will be opened for every 1000 population, and 700 in case of tribal areas. It noted that six lakh AWCs had been opened, and ordered that all of them should be made operational by 30th June, 2004. The sanctioned AWCs were to supply nutritious food to the beneficiaries for 300 days in a year under the ICDS scheme. Reports were called from the Chief Secretaries to indicate how many children, adolescent girls, lactating women and pregnant women were provided with nutritious food in the number of days in the year. On 13th December 2006, further directions were issued by the Supreme Court. It was observed that the universalisation of ICDS "involves extending all ICDS services to every child under the age of 6, all pregnant women, lactating mothers and adolescent girls."

## The AAY

…

17. In its order dated 17th November 2004, the Supreme Court noted that the AAY was "meant for the poorest of the poor." It went on to observe that:
"A person entitled to the benefit under this scheme is issued a red card. The holder of red card entitles him/her to obtain grain and rice from the dealer of Public Distributor System (PDS) at a highly subsidised rate …. First of all it is of utmost

importance that those who have already been issued red card shall straightway be supplied the rice and grain as per their entitlement. It is also important that those falling under this category should be immediately identified. The special attention is required to be given to Primitive Tribal Groups, which we are told, are in large in Maharashtra, West Bengal, Jharkhand and Madhya Pradesh, which are still be to identified in large numbers, card issued and grains supplied. We direct all the State Governments to complete the process of identification of persons falling under this scheme and issue them the red card by the end of the year so that immediately thereafter supply of food grains to them may commence."

## The NRHM

…

The essential thrust of the NRHM is of "convergence" of different schemes. The idea is to put in place a system that facilitates easy accessibility of the public health systems while at the same time making it accountable.

The Constitutional right to health and reproductive rights

19. A conspectus of the above orders would show that the Supreme Court has time and again emphasised the importance of the effective implementation of the above schemes meant for the poor. They underscore the interrelatedness of the "right to food" which is what the main PUCL Case was about, and the right to reproductive health of the mother and the right to health of the infant child. There could not be a better illustration of the indivisibility of basic human rights as enshrined in the Constitution of India. Particularly in the context of a welfare State, where the central focus of these centrally sponsored schemes is the economically and socially disadvantaged sections of society, the above orders of the Supreme Court have to be understood as preserving, protecting and enforcing the different facets of the right to life under Article 21 of the Constitution. As already noted, these petitions focus on two inalienable survival rights that form part of the right to life. One is the right to health, which would include the right to access government (public) health facilities and receive a minimum standard of treatment and care. In particular this would include the enforcement of the reproductive rights of the mother and the right to nutrition and medical care of the newly born child and continuously thereafter till the age of about six years. The other facet is the right to food which is seen as integral to the right to life and right to health.

20. The right to health forming an inalienable component of the right to life under Article 21 of the Constitution has been settled in two important decisions of the Supreme Court: Pt. Parmanand Katara v. Union of India (1989) 4 SCC 286 and

Paschim Banga Khet Majoor Samiti v. State of West Bengal (1996) 4 SCC 37. The orders in the PUCL Case are a continuation of the efforts of the Supreme Court at protecting and enforcing the right to health of the mother and the child and underscoring the interrelatedness of those rights with the right to food. This is consistent with the international human rights law which is briefly discussed hereafter.

21. Article 25 of the Universal Declaration of Human Rights, which is considered as having the force of customary international law, declares:

Article 25

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

22. The International Covenant on Economic, Social and Cultural Rights (ICESCR), which has been ratified by India, spells out in greater detail the various facets of the broad right to health. Articles 10 and 12 of the ICESCR which are relevant in this context, read as under:

Article 10

1. The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses.

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.

3. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. ...

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

23. The Committee on Economic Social and Cultural Rights has in its General Comment No. 14 of 2000 on the right to health under the ICESCR explained the scope of the rights as under:

"8. The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health. ...

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels. ...

14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a)) may be understood

as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."

24. The reproductive rights of women have been accorded recognition, and the obligations of States have been spelt out in the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) which is another international convention ratified by India. The relevant provisions of the CEDAW in this context are:

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 I 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 14

1. States Parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:

(a) To participate in the elaboration and implementation of development planning at all levels;
(b) To have access to adequate health care facilities, including information, counselling and services in family planning;
(c) To benefit directly from social security programmes;
(d) To obtain all types of training and education, formal and non-formal, including

that relating to functional literacy, as well as, inter alia, the benefit of all community and extension services, in order to increase their technical proficiency;

(e) To organize self-help groups and co-operatives in order to obtain equal access to economic opportunities through employment or self employment;

(f) To participate in all community activities;

(g) To have access to agricultural credit and loans, marketing facilities, appropriate technology and equal treatment in land and agrarian reform as well as in land resettlement schemes;

(h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.

25. The Child Rights Convention (CRC) which has also been ratified by India delineates the rights of the newly born and the young child thus:

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

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

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

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

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

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 27

1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.

3. States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.

4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.

26. International human rights norms as contained in the Conventions which have been ratified by India are binding on India to the extent they are not inconsistent with the domestic law norms. The Protection of Human Rights Act, 1993 (PHRA) recognises that the above Conventions are now part of the Indian human rights law. Section 2(d) PHRA defines "human rights" to mean "the rights relating to life, liberty, equality and dignity of the individual guaranteed by the Constitution or embodied in the International Covenants and enforceable by courts in India" and under Section 2(f) PHRA "International Covenants" means "the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights adopted by the General Assembly of the United Nations on the 16th December, 1966."

27. The orders in the PUCL Case implicitly recognize and enforce the fundamental right to life under Article 21 of the Constitution of the child and the mother. This includes the right to health, reproductive health and the right to food. In effect, the Supreme Court has spelt out what the "minimum core" of the right to health and food is, and also spelt out, consistent with international human rights law, the "obligations of conduct" and the "obligations of result" of the Union of India, the States and the UTs. While recognizing the indivisibility of civil rights and social and economic rights, the Supreme Court has made them enforceable in courts of law by using the device of a "continuing mandamus." On their part, the High Courts in this country would be obligated to carry forth the mandate of the orders of the Supreme Court to ensure the implementation of those orders within the States and UTs. This then forms the background to this Court's intervention in these petitions.

**Facts of the two Cases:**

## Shanti Devi and her daughter Archana

28.1 The facts stated in W.P.(C) No. 8853 of 2008 show that Shanti Devi was born in a poor family in Bihar. She was married to Kishan Mandal. Shanti Devi and her family shifted to Faridabad for better means of employment for her husband. Shanti Devi, at this point, had two children, however, she had had four pregnancies, wherein two resulted in the death of the foetus or the child. Generally, Shanti Devi was of poor health and suffered from anemia and tuberculosis.

28.2 When Shanti Devi was in the 7th month of her fifth pregnancy, she was suffering from severe oedema, severe anemia and fever. She had also suffered from a fall on the stairs of the building where she was residing. She saw a Dai (midwife) as she could not afford to see a doctor. The Dai advised that she should be taken to Faridabad Hospital. She could only be taken to the hospital by her husband after a period of two weeks (or more), as she did not have the finances for the same. By this time, neither the Dai nor Shanti Devi could feel the baby moving inside her stomach.

28.3 She was brought to the Faridabad Hospital on 19 th November 2008. Despite discovering that Shanti had miscarried the baby, the Faridabad Hospital did not give medicines for alleviation of pain or suffering to Shanti, instead she was referred to Sanjay Gandhi Hospital, New Delhi. The dead foetus was still in Shanti and she was severely aneamic at this point.

28.4 At Sanjay Gandhi Hospital, it was threatened that Shanti would not be treated if 4 bottles of blood were not provided to her immediately. After receiving blood, she was kept for 3 days, however, she was then advised to go to Saroj Hosptial, as Sanjay Gandhi Hospital did not have sufficient facilities - a bed in the Intensive Care Unit (ICU) for the removal of the foetus. On 22nd November 2008 Shanti Devi and her husband arrived at Saroj Hospital with a resident doctor of Sanjay Gandhi Hospital. The documents which proved that Shanti Devi was a BPL who needed urgent medical attention at no cost were provided. After the resident doctor left, Saroj Hospital refused treatment on the ground that she was not BPL and demanded 2.5-3 lakhs from Shanti Devi for the treatment. The Medical Superintendent at Sanjay Hospital did enquire with Saroj Hospital of the reasons for not admitting Shanti Devi.

28.5 After being denied treatment in Saroj Hospital, Shanti Devi was thereafter taken back to Sanjay Gandhi Hospital, from where she was referred to and treated at Deen Dayal Hospital. Here, it was diagnosed that she was suffering from lack of platelets derangement which occurs when women lack protein during pregnancy. The foetus was removed from her body.

28.6 On 12th December 2007 this writ petition was filed, praying for compensation, and for the State to abide by the National Rural Health Mission and the Janani Suraksha Yojana.

28.7 On 7th January 2009 this Court passed an order that Shanti Devi should be admitted and treated at Deen Dayal Hospital free of cost. The said order reads as under:
"Ms. Sonia Mathur has produced original records of Deen Dayal Upadhyay Hospital, Hari Nagar, New Delhi. Mr. Ashok Aggarwal, learned counsel is present in Court. He submitted that pursuant to the directions of the Division Bench in "Social Jurist v. Govt. of NCT of Delhi" in Petition No. 2866/2002, he was appointed as Member of the Monitoring Committee for proper implementation of such policies. According to him, an offer was made to the petitioner's sister to have her admitted in the Saroj Hospital which was not accepted.

After hearing counsel, the Court is of the opinion that the petitioner's sister should be immediately admitted to the Deen Dayal Hospital, Hari Nagar, New Delhi. Ms. Sonia Mathur assures that this would be done forthwith. Since there is no denial that the petitioner's sister is to be categorized as Below Poverty Line citizen, the respondent shall not charge any amount for treatment or diagnostic intervention or investigation.
..."

28.8 Shanti Devi became pregnant for the sixth time. On 28th January 2010 Shanti Devi died after giving birth to a pre-mature baby. She delivered at home without the presence of a skilled birth attendant. The daughter from Shanti Devi's sixth pregnancy, Archana was admitted at BK General Hospital at Faridabad in Haryana. However, it was feared that the BK General Hospital, Faridabad, could turn out Shanti Devi's daughter, as her father did not have a BPL ration card issued in Haryana. The above facts were brought to the attention of this Court which passed the following order on 28th January 2010: [See above.]

28.9 Pursuant to the above order, Archana was shifted to Chacha Nehru Bal Chikitsalaya, Delhi. Thereafter she has been with her father and other relatives in Nangloi, New Delhi.

28.10. This Court on 8th March 2010 accepted the request of the petitioners that a maternal audit of the death of Shanti Devi be conducted by an expert, Dr. Prakasamma …. Dr. Prakasamma has submitted a comprehensive report. The summary of the report is that:

(i) direct cause of Shanti Devi's death was the Extensive Hemorrhage (PPH) with Retained Placenta. However, there were many indirect and contributing factors to her death, which broadly include, her dismal socio-economic status which denied access to needed resources and services, and her poor health condition which is a culmination of anemia, tuberculosis and repeated, unsafe pregnancies.

(ii) Shanti Devi had severe anemia. Anemia is a major public health problem in India, as about half of the population of India is anemic. Women suffering from anemia have to face an additional burden when they become pregnant, because of the increased demand for nutrition. In India, anemia is responsible for 17% of maternal deaths, and the case fatality rate of pregnancy anemia approaches 6-17%.

(iii) Shanti Devi also suffered from Tuberculosis, even before she and her husband shifted to Faridabad (2005). There is scientific data which shows that tuberculosis definitely increases the risk of prematurity, small for the gestational age, neonatal morbidity and mortality. If Shanti's TB would have been prevented or treated in the beginning stages, Shanti would not have faced so many risks and ultimately died after her sixth delivery with retained placenta and haemorrhage. "Like Shanti, there are several women with TB in the same building. There is a DOTS centre nearby. When we visited the centre and spoke to the ANM, Ms. Kaushalya, about the number of women who were

on TB drugs, she said her records were not with her as she had left them at home. Discussion with ASHA (title for a person concerned and appointed for implementation of Janani Suraksha Yojana) who was also present in the subcentre revealed that Shanti Devi was not registered at the DOTS centre."

(iv) Shanti fell from unprotected steps of her home during the seventh month of her fifth pregnancy. The fracture resulted in humerus (L), and multiple fracture ribs and could caused the death of foetus. The rib fractures could have further exacerbated the respiratory distress. She was taken to the hospital only two weeks after realizing that she did not have foetal movements.

(v) Shanti Devi was reported to be sick and thin and sat depressed all the time, especially, during the last pregnancy.

(vi) She faced poor living conditions, low access to food, information, resources, services which reduced her capacity to cope up with her physiological processes. Tuberculosis and anemia are the result of poverty and inadequate access to resources and services.

(vii) Shanti Devi's was born in Bihar which has been behind the rest of India in socio-economic and health indicators, more specifically, in this case, it has a high birth rate, highly unfavourable ratio of women to men, low female literacy, higher incidence of death due to childbirth, higher percentage of anemic married women, etc.

(viii) Shanti Devi and her family shifted to Faridabad for better means of employment for her husband. Due to this migration, they did not have a ration card in Faridabad, despite repeated attempts to obtain the same. Consequently, they did not have access to subsidized food, education and health facilities, and could not avail of the entitlements of JSY.

(ix) Out of her six pregnancies, only 2 were institutional deliveries, and they were for evacuation of foetus. It is assumed that institutional deliveries are safe because they are conducted by skilled and qualified personnel. However, the functionality and responsiveness of the institutes is questionable. The attitude and prompt response of the providers is a major factor in whether the women use these facilities. In Bihar, less than a quarter of the deliveries take place in institutions.

(x) There are differing versions with what happened at Saroj Hospital. Malati, Lakshmi Mandal's wife said that when she spoke to the patients and attendants at the Hospital, while Shanti was being examined, she was told that "no one got free treatment in this hospital and that it would cost lakhs!" The hospital staff asked her to keep half a lakh rupees ready. According to her, the hospital reception asked them to either pay the money or produce a BPL card, the statement of SGMH was not sufficient to admit the patient as a BPL.

(xi) There is inconsistency in the statements of the staff. Further, incorrect treatment was administered to Shanti Devi by a Obstetrician, Dr. Yashoda Karru. The hospital claims that the patient left against medical advice, however, it is unclear whether the hospital clearly explained the situation to the patient's relatives, considering that the patient was immediately rushed to SGMH. Further, was a private corporate hospital sufficiently sensitive and informed in the manner that BPL patients should be interacted with?

(xii) There is no evidence that she received counselling and follow-up after discharge from hospital (after her 5th pregnancy). However, her relatives have positively affirmed that she and her husband were counseled about family planning before they were discharged from Deen Dayal Hospital. When questioned, Kishan said that he was informed that another pregnancy would lead to serious problems and will be a threat to her life. Lakshmi Mandal and his wife, Malati blame Kishan for not taking precaution to prevent pregnancy. Notably, despite having several occasions/ opportunities to do so, hospitals failed to refer Shanti Devi for counseling on family planning.

(xiii) Subcentre records could not reveal that her pregnancy was registered, or that she received any facilities or advice. Her maternal death was not audited either, despite the Government Circular. Research shows that a small proportion of the maternal deaths are actually reported. ANM Kaushalya said that she did not report Shanti Devi's maternal death as she was afraid that she would be blamed for neglect.

(xiv) 102 services toll free number was not used. Shanti Devi's family hesitated to go to the hospital and feared that they will not be received.

One important finding in the report submitted by Dr. Prakasamma is that the primary cause of Shanti Devi's death was postpartum haemorrhage due to retained placenta.

## Fatema and Alisha

29.1 The facts as narrated in the companion writ petition, W.P. No. (C) 10700 of 2009, are that Fatema, daughter of the Petitioner Jaitun, is a poor, uneducated woman and suffers from epilepsy fits. She is homeless, living under a tree in Jangpura in New Delhi. Her husband abandoned her after she became pregnant. On 30th December 2008 and 17th March 2009, Fatema went to a Maternity Home run by the Municipal Corporation of Delhi (MCD), Jangpura for vaccination, and inquired about the cash benefits that she could avail upon delivery. However, she received no response much less assistance from the authorities.

29.2 On 29.5.2009 Fatema, delivered her child Alisha, in full public view, without access to skilled health care and medical guidance. Fatema delivered her child Alisha under a tree. Subsequently, on the same day, the Petitioner Jaitun informed the Maternity Home of the delivery. However, no visit was made by the staff of the Hospital.

29.3 On 3rd June 2009, the Petitioner, Fatema and her child went to the Maternity Home, MCD for the child's vaccination, however, the child did not undergo any medical check-up under the Service Guarantee of NRHM, neither was she given advice, nor was she given medicines. On 5th June 2009, Fatema was advised that she is anemic, without conducting any blood test on her. She was administered medicines and issued a discharge slip, which the staff of the Maternity Home explained, was the only way for her getting a birth certificate for her daughter and to get a cash assistance under the JSY. The particulars in the slip were in English and therefore unintelligible to Fatema. Jaitun and Fatema made a number of visits thereafter to the Maternity Home but were refused payment. It appears that ultimately Jaitun was able to get Rs. 550 from the Maternity Hospital primarily on account of the intervention of a social activist. It is the petitioner's case that despite repeated requests, Fatema never received transportation costs to and from the Maternity Hospital.

29.4 In these circumstances, the present writ petition was filed by Fatema's mother Jaitun praying for compensation, proper implementation of schemes and providing Fatema and her daughter with nutrition and health care. On the date of filing the writ petition, Fatema's health condition had significantly deteriorated (anemia and epilepsy fits), but, she had not been visited by the Anganwadi worker or by the ANM. Neither Fatema nor her child received the benefits under the ICDS scheme, the AAY scheme and the NMBS scheme.

29.5 It is submitted in the writ petition that, the AWC at Nizam Nagar, Nizamuddin was visited on three occasions by a social activist associated with an NGO, however,

the AWC would remain closed most of the time, it would be open for about one hour every day. In this one hour, childre n were given some halwa. However, it is submitted that this halwa scarcely met their dietary needs. The community residing around the AWC was not aware of the services which AWC was to provide. The AWC did not run in a separately rented place, but in a room, where a family permanently resides. The petition points out that the AWC has a highly unsatisfactory infrastructure. There is no board outside the AWC, which would signify its presence.

29.6 On the date of filing this petition, Fatema's daughter Alisha's health was deteriorating, as she had not received milk (breast milk or through bottles). The petitioner stated that Fatema herself was very ill and did not produce breast milk. There was no money for buying milk.

29.7 On 8th January 2010, this Court passed the following order: [See above.]

Thereafter on 13th January 2010 Fatema received the AAY card and the cash benefit of Rs. 500 under the NMBS.

**Response of the Union of India and the States**

30. The Union of India, the GNCTD and the State of Haryana have filed their responses to the petitions and to the specific queries posed by this Court in its orders.

31. The Government of India in its affidavit dated 26th May 2010, by the Under Secretary in the Ministry of Health and Family Welfare, Government of India stated, "regarding the two specific cases, the State Governments of NCT of Delhi and Haryana are replying on the status of implementation of the order of the Supreme Court." The stand otherwise of the Government of India is that the responsibility for implementation of the schemes is essentially with the State governments. Although it is claimed that there is some kind of a review undertaken of the working of the schemes in the states, and this has been provided for in the JSY document it is not in dispute that these two instances were not brought to the notice of the central government. There does not also appear to be any inbuilt mechanism for corrective action, restitution and compensation in the event of the failure of any beneficiary to avail of the services under the schemes. This, despite the fact that under the NRHM there are service guarantees and that JSY document also requires strict implementation by the state governments.

31. The Government of NCT of Delhi has filed an affidavit of its Director, Health & Family Welfare Department giving information on how the NCT of Delhi has implemented the schemes. As regards the facts of these two petitions the response of the Department of Women and Child Development, GNCTD is that Alisha has been registered in the AWC of the ICDS Nizamuddin Project, and is getting weaning food (panjiri) as take home ration worth Rs. 5/- per day within the prescribed Calorie and Protein norms (500 Calories and 12-15 Gms. of Protein). As regards Archana, it is stated that the child is eligible for supplementary nutrition under ICDS Scheme and health services can be availed by her in convergence with the Health Department by approaching the nearby AWC in Nangloi where she is residing. It is further stated that the health services are being provided to Alisha in convergence with the local MCD dispensary. She has already received due dosages of DPT and Measles. Her mother Fatima is also getting medical treatment from the GB Pant Hospital after being referred to the local MCD dispensary according to the CDPO Nizamuddin.

32. The Government of Haryana has filed an affidavit of its Programme Officer, Dist. Integrated Child Development Services Cell, Faridabad. While referring to the ICDS scheme it states, "that the child (baby of Shanti Devi and Kishan Mandal) can be benefitted to the above mentioned Schemes, run by the Women and Child Development Department, Haryana provided, she fulfils the eligibility criteria."

33. In the additional affidavit of the Civil Surgeon, Faridabad dated 1st June 2010 with respect to the JSY scheme, it is stated that "Smt. Shanti Devi was advised by the concerned ANM (Mrs. Kaushalya) in Nov./Dec. 2009 and she was given T.T. injection and iron tablets." According to this affidavit "the ANM advised and ready to help Smt. Shanti Devi to get checked at PHC Palla. But Smt. Shanti Devi refused to go. The ANM also advised her husband to get the BPL card and SC certificate so that they can avail the benefits of JSY (GOI) and JSY (State). But her husband was reluctant."

34. The affidavit states that the expected date of delivery was 20th March 2010. It was a premature delivery. The baby was born on 20th January 2010. Shockingly, the affidavit states: "It was an unexpected and unwanted event. Therefore, she could not get any help/assistance from ANM and ASHA."

## Analysis of facts

35. As Dr. Prakasamma's report, which has not been countered by the Respondents, shows the direct cause of Shanti Devi's death was the Extensive Haemorrhage

(PPH) with Retained Placenta. However, there were many indirect and contributing factors to her death, which broadly include, her dismal socio-economic status which denied access to needed resources and services, and her poor health condition...

36. Dr. Parkasamma's report shows that Smt. Shanti Devi was a high risk patient and advised by the Doctors not to go in for a sixth pregnancy. During her fifth pregnancy in 2008, she had an intrauterine death, retained placenta leading to coagulation disorder. She had also T. B., Bronchiectasis and breathing difficulty. She had fracture of Humerus and multiple fracture ribs. She therefore needed to be constantly monitored and counselled.

37. In neither of the cases of Fatema or Shanti Devi were the substantiatve benefits under the JSY schemes made available. In Fatema's case, as the hearing of these cases progressed, the GNCTD incrementally came up with which purportedly showed that Fatema had been receiving attention at the MCD's clinic at Jangpura. However, these sporadic documents do not give complete picture. One of them has an endorsement presumably made by Jaitun that she is now getting the rations but that she has to make three or four visits. It is not clear at all that during her pregnancy, Fatema received the benefits. It is claimed that she was given immunization on two or three occasions. A photocopy of the JSY card issued for Fatima was produced. Again it is not known whether Fatima was indeed given this card and whether she used it to get the benefits. There is no register produced to show disbursal of cash assistance to Fatema under the NMBS before she delivered Alisha. It is only after the Court's intervention that she received the AAY card and the NMBS benefit.

38. In Shanti Devi's case also an attempt was made to show that an ASHA visited her and the photocopy of the register maintained by such ASHA was produced. This however does not inspire confidence as it does not appear to have been countersigned or checked. Clearly, closer to the expected date of delivery i.e. 20th March 2010, the visits by the ASHA were either non- existent or infrequent. Likewise in the case of Fatema, there is no record of her being visited by any ASHA or being given assistance for home delivery.

39. A significant feature of both cases is that both women delivered their babies outside of the institution. The schemes envisage that even for home deliveries, assistance has to be provided to the pregnant women. In the case of Fatema this Court has been shown a report of Dr. Indrani Sharma which appears to suggest that she delivered a baby in her jhuggi. It is not understood on what basis this report has been prepared. It is however contradicted by the photographs enclosed with the

petition which indicate that the baby was indeed delivered under a tree. Be that as it may, there is no record of immediate post delivery assistance being afforded to Fatema and Alisha as mandated by the JSY.

40. Both the cases point to the complete failure of the implementation of the schemes. With the women not receiving attention and care in the critical weeks preceding the expected dates of delivery, they were deprived of accessing minimum health care at either homes or at the public health institutions. As far as Shanti Devi is concerned, the narration of facts concerning her fifth and sixth pregnancy show that she was unable to effectively access the public health system. ... The quality of services rendered in the private hospital to which Shanti Devi was referred during the fifth pregnancy is a matter for concern. It points to the failure of the referral system where a poor person who is sent to a private hospital cannot be assured of quality and timely health services.

41. However, what is clear is that there does not appear to be a system requiring increased visits by the ASHA or ANM, closer to the actual expected date of delivery. Unless this is done, it may be difficult for a pregnant woman with complications to be immediately shifted to an institution for an institutional delivery. With the possibility of babies being delivered prematurely not being able to be completely ruled out, the increased visits by the ANM at least two months prior to the expected date of delivery would ensure the arrangement of ambulance to shift the woman who is facing complications or who may develop labour pain to be immediately shifted to hospital. The woman may require delivery through cesarean operation in which case she also would be required to move to the Government health center with such facilities without delay.

42. It was sought to be urged that the ANM advised Shanti Devi that she should come for institutional delivery and she simply refused. With Shanti Devi not around anymore, it is very difficult to verify this kind of a statement. Be that as it may, given that an important component of the JSY is counseling of a pregnant woman, if during the stage of pregnancy and needing critical care, a woman is unwilling to avail of such services, it would be incumbent upon the ASHA or the ANM concerned to immediately report the matter to the ANM/MO who will then make such efforts by counselling the pregnant woman and impressing upon her family to shift her to the hospital. This was not done in Shanti Devi's case.

43. As far as the NMBS is concerned, it envisages a one-time cash assistance of Rs.500/- at least 8 to 12 weeks prior to the delivery. While after the Court's order Fatema received the cash assistance, Shanti Devi died without receiving it. Even now the

State of Haryana has not paid the said cash assistance to the legal representatives of Shanti Devi.

## Confusion regarding cash assistance under the NMBS

44. There has been a doubt whether cash assistance under the NMBS is independent of the cash assistance under the JSY. The order dated 20th November 2007 of the Supreme Court leaves no manner of doubt that this is a separate benefit and has to be provided 8 to 12 weeks prior to the actual date of delivery.

45. The Central Government has taken shelter under paragraph 15 of the order dated 20th November 2007 of the Supreme Court which reads as under:

> "15. At this juncture it would be necessary to take note of certain issues which have relevance, it seems from the scheme that irrespective of number of children, the beneficiaries are given the benefit. This in a way goes against the concept of family planning which is intended to curb the population growth. Further the age of the mother is a relevant factor because women below a particular age are prohibited from legally getting married. The Union of India shall consider this aspect while considering the desirability of the continuation of the scheme in the present form. After considering the aforesaid aspects and if need be, necessary amendments may be made."

46. Pursuant to the above directions, an interlocutory application was filed in the Supreme Court seeking modification of its mandatory directions in the order dated 20th November 2007 to the effect that "the Union of India and all State Governments would continue with the NMBS" and "ensure that all BPL pregnant women get cash assistance 8 to 12 weeks prior to the delivery." Further it was mandated that the amount shall be Rs.500/- per birth irrespective of number of children and the age of the woman. Yet, after filing the interlocutory application, in which no order has been passed as yet by the Supreme Court, the State Governments have been instructed to continue following the earlier patterns of denying cash assistance after two live births. Clearly, this is a confusion created by the Central Government at two levels. First by treating the cash assistance under the NMBS as forming part of the cash assistance under the JSY and, therefore, applying the same yardstick. Secondly, in restricting the cash benefit under the NMBS to two live births when clearly the Supreme Court's order says to the contrary.

47. As a result of the above confusion created by the Central Government, millions of pregnant women across the country have, despite the order dated 20th November 2007, been deprived of this cash assistance. While Rs.500/- may not seem substantial

to a salaried middle class person in this country but it means a lot to a pregnant woman struggling to make ends meet.

48. An argument was advanced by Mr. A.S. Chandhiok, learned Additional Solicitor General ("ASG") by drawing an analogy with the allotment of alternate accommodation to a slum dweller, that there is an apprehension that the benefit under the scheme would be "misused". This Court finds this apprehension to be misplaced. Given the status of the facilities available in Government hospitals and primary health centers across the country, it is very unlikely that any person who can otherwise afford health care is going to "misuse" these facilities. On the other hand, when it comes to the question of public health, no woman, more so a pregnant woman should be denied the facility of treatment at any stage irrespective of her social and economic background. This is the primary function in the public health services. This is where the inalienable right to health which is so inherent to the right to life gets enforced. There cannot be a situation where a pregnant woman who is in need of care and assistance is turned away from a Government health facility only on the ground that she has not been able to demonstrate her BPL status or her "eligibility". The approach of the Government, both at the Centre and the States, in operationalising the schemes should be to ensure that as many people as possible get "covered" by the scheme and are not "denied" the benefits of the scheme. Instead of making it easier for poor persons to avail of the benefits, the efforts at present seem to be to insist upon documentation to prove their status as "poor" and "disadvantaged". This onerous burden on them to prove that they are the persons in need of urgent medical assistance constitutes a major barrier to their availing of the services. This is one reason why the coverage under the schemes has been poor in all these years and has required active intervention by the Supreme Court.

49. The affidavits filed both by the Government of Haryana as well as the GNCTD reflect that the coverage of beneficiaries under the schemes is indeed improving. Yet the artificial distinction drawn between HPS which presumably include Delhi and Haryana, and the LPS, may actually result in the pregnant women in urgent need in Delhi and Haryana being deprived of it. While the logic of depriving cash assistance beyond two live births even in HPS cannot be justified on any rational basis particularly since women in the Indian social milieu have very little choice whether she wants to have a third child or not, the other benefits under the JSY and other claims obviously cannot be denied to any woman irrespective of the number of live births.

50. Till this Court passed the necessary orders, the AAY card was not given to either Fatema or to the family of Shanti Devi. Sadly during her life time Shanti Devi did not get the benefit offered under the AAY or the ICDS. This is a major failure which aggravated the causes that ultimately led to her death. As far as Fatema was concerned, after the delivery of the baby under a tree, the GNCTD appears to have got its act together to provide her with an AAY card and to ensure that her baby Alisha is receiving good food at the Aanganwadi Center of the ICDS. All this happened, of course, only after the intervention of this Court.

**Reparations and reliefs**

51. The question that next arises is how reparations be made for the failure to implement the schemes in both these cases during the time when both women were pregnant. Fortunately in Fatema's case the baby and the mother survived. In Shanti Devi's case she died giving birth to the child at her residence in Faridabad. This was the second time she was being denied the assistance under the scheme. ... The constant monitoring and care envisaged by the JSY was completely absent in her case on both the occasions.

52. It was not denied by learned counsel appearing for the Government of Haryana, the GNCTD as well as the Central Government that as of now there is no inbuilt component for reparations under the schemes. Given that the budget outlay of the schemes is in several hundreds of crores, it is indeed surprising that there is no inbuilt component for reparations. The Petitioners on their part have asked that compensation be awarded to the family of Shanti Devi for her death which resulted as a failure by the Government of Haryana, and the GNCTD to provide the benefits under the above schemes. Likewise, compensation has been claimed for Fatema as well.

53. It may be difficult to quantify the actual loss suffered by either family as a result of the failure by the State Government to deliver the benefits under the schemes to each of these women during their pregnancies. What is clear in Shanti Devi's case is that the maternal mortality was clearly avoidable.

54. In the case of Fatema soon after the baby was delivered, she required nutrition and supplements which were denied till the Court's intervention. Even the ICDS benefits were given only after the Court's intervention. It is well possible that but for the Court's intervention, the baby and the mother may have been deprived of the benefits which would have caused irreparable injury and possibly loss of life.

55. Having considered these circumstances, the Court issued the following directions as regards Writ Petition (C) No. 8853 of 2008 concerning the family of baby Archana, the daughter of late Shanti Devi.

(a) The GNCTD will refund forthwith to Shanti Devi's husband Rs.1,000/- charged by the DDU Hospital from Shanti Devi for her treatment since that treatment was free.

(b) The sum of Rs.500/- will be paid forthwith to Shanti Devi's husband by the GNCTD under the NMBS.

(c) The AAY card will be made forthwith for the family of baby Archana.

(d) Under the Apni Beti Apna Dhan Scheme, the State of Haryana will give Rs.500/- to Archana through her father. Indira Vikas Patras of Rs.2,500/- in the name of baby Archana forthwith be handed over to her father.

(e) Under the Balika Samridhi Yojana Scheme launched by the Government of India, a sum of Rs.500/- being given as post- birth grant to the mother will now be given to Archana's father. In addition, the following benefits will be ensured during Archana's growing years:
"Class Amount of Annual Scholarship I-III Rs. 300/- per annum for each class
IV Rs. 500/- per annum
V Rs. 600/- per annum
VI-VII Rs. 700/- per annum for each class
VIII Rs. 800/- per annum
IX-X Rs. 1,000/- per annum for each class"

(f) Under the NFBS, Shanti Devi will be recognized as a "primary bread winner" and a sum of Rs.10,000/- will be given to her husband and to the children forthwith.

(g) In addition to the above, for the avoidable death of Shanti Devi a sum of Rs.2.4 lakhs be paid by the State of Haryana within a period of four weeks to the family of Shanti Devi of which Rs. 60,000/- will be paid to Shanti Devi's husband and Rs.60,000/- each be kept in a fixed deposit in a nationalised bank in Delhi in the names of Shanti Devi's two sons and Archana which will be kept renewed till each child completes 21 years. The interest on the fixed deposits will be credited to the savings bank account of their father and after each child

attains majority to their respective savings bank accounts. After their 21st year, each child can encash the fixed deposits.

56. In W.P.(C) No. 10700 of 2009, pursuant to the orders passed by the Court, Fatema has been paid Rs.500/- cash assistance under the NMBS. She was given an AAY card. A complaint was made that she has not been given the 35 Kg. of grains, sugar and kerosene oil for the last three months. An officer from Food & Supplies Department of the GNCTD present in the Court assured that he will have this complaint immediately examined and ensure that Fatema receives the full quota of 35 Kg. under the AAY card.

57. Fatema is a patient of epilepsy and shall continue to receive her medication every 15 days from the Maternity Home of the MCD at Jangpura. She will undergo a medical check-up every two months at the G.B. Pant Hospital. If required, an ambulance will be arranged at the Maternity Home, Jangpura for taking her to the G.B. Pant Hospital for future check-ups.

58. The baby Alisha is entitled and shall be granted the comprehensive benefits under the ICDS in terms of the orders dated 20th November 2007 passed by the Supreme Court in W.P.(C) No.196 of 2001. There appears to be some correction required to be made in the birth certificate issued for Alisha. The Respondent MCD will render necessary assistance to Fatema to have the correction carried out.

59. Alisha is entitled to all the benefits under the BSYS as recast by the Government of India in 1999-2000. Accordingly, the following benefits shall be extended to baby Alisha:
"Class Amount of Annual Scholarship I-III Rs. 300/- per annum for each class
IV Rs. 500/- per annum
V Rs. 600/- per annum
VI-VII Rs. 700/- per annum for each class
VIII Rs. 800/- per annum
IX-X Rs. 1,000/- per annum for each class"

60. In addition to the above, the GNCTD has announced a Ladli Scheme under which financial deposit in the sum of Rs.10,000/- has to be made in the name of the girl child after 1st January 2008. The said benefit will be extended to Alisha within a period of four weeks from today.

61. For the violation of the fundamental rights of Fatema by being compelled to give birth to Alisha under a tree which is only on account of the denial of basic medical

services to her under the various schemes, the MCD and the GNCTD will jointly and severally be liable to pay her compensation in the sum of Rs.50,000/- within a period of four weeks from today. The said amount will be placed in a fixed deposit for a period of three years in the name of Fatema in an account to be opened in a nearby nationalized bank with the facility of transferring the interest accrued thereon every quarter to her savings account which can even be withdrawn by her. She would be able to encash the fixed deposit after a period of three years.

Shortcomings in the implementation of the schemes

62. This Court notices the following shortcomings in the working of the schemes:

(i) There is no assurance of "portability" of the schemes across the states. In the present case, Shanti Devi travelled from Bihar to Haryana and then to Delhi. In Haryana she was clearly unable to access the public health services. At Delhi she had to once again show that she had a BPL card, and on being unable to do so, she was denied access to medical facilities. For the migrant workers this can pose a serious problem. Instructions will have to be issued to ensure that if a person is declared BPL in any state of the country and is availing of the public health services in any part of the country, such person should be assured of continued availability of such access to public health care services wherever such person moves.

(ii) There is confusion on whether the cash assistance under the NMBS scheme is independent of the cash assistance under the JSY scheme, despite the Supreme Court making this unambiguously clear by its order of 20th November 2007 in the case of PUCL v. Union of India. Further it appears that benefit under the NMBS is being denied to women who have had more than two live births and to women who are under 19 years of age, although the Supreme Court's order dated 20th November 2007 makes it clear that such benefits should be made available irrespective of the number of live births or the age of the mother. The necessary clarification requires to be immediately issued by the Central Government to all the State Governments in this regard so that pregnant women across the country are not denied cash assistance.

(iii) There is an overlap of the schemes. The ICDS is administered by the Department of Women and Child Development of the State, the NRHM by the Ministry of Health at the centre and JSY by the Health Ministries of the States. There must be an identified place which the women can approach to be given the benefits under the various schemes. In other words, a pregnant

woman or a lactating mother should not have to run to several places to get benefits under the schemes.

(iv) The system of administering the IWC under the ICDS requires to be overhauled. AWCs even in Delhi appear to operate from single rooms which are inadequate for the number of children who have to be served at the AWC. AWCs are seen to be in a deplorable condition. There is nothing in the form of any label/ board to indicate their presence. They also do not appear to have the necessary equipment to carry out the necessary tests. In the rural set up, it should be possible to have a monthly camp held at an identified place where the pregnant women and young children can undergo health check-up.

(v) The system of referral to private health institutions has to be improved. Safe and prompt transportation of pregnant women from their places of residence to public health institutions or private hospitals and vice-versa needs to be ensured. The critical days and hours prior to the expected date and time of delivery can be a matter of life or death for a pregnant woman. If adequate ambulance services are not available at that stage, many a life will be needlessly lost. The two cases here show the Court orders were required at various times even to remove the baby for critical care from one hospital to another. Even in places like Delhi, the ambulance and transport services require to be augmented and improved significantly.

(vi) The NFBS envisages the payment of sum of Rs. 10,000/- in the event of death of the "primary bread winner." It is also necessary to recognize a woman in the family who is a home maker as a "bread winner" for this purpose. In the event of a maternal death, the family should get the cash benefit under the NFBS. It should be ensured that this is made available to her legal heirs as per their legal entitlement. Necessary instructions clarifying this position will have to be issued by the Central Government to the State Governments.

(vii) The statistics furnished by the State Governments on the performance of the JSY show the number of institutional deliveries but do not indicate what percentage of the total number of deliveries in the State they constitute. Only when such information is available and provided under the schemes, the categorization of States as HPS and LPS is possible. The Central Government must insist on this kind of information for meaningful assessment of the working of the schemes.

(viii) On the working of the AAY, it appears that the benefits are not reaching to the pregnant women, particularly those who migrate from one State to

another. This problem will require urgent attention at the hands of the Central Government, the State Governments and the UTs. There is also a problem of portability of the AAY benefit. Unless the poor woman is assured of the AAY benefits notwithstanding having to travel from one State to another, the scheme cannot be said to be effective.

(ix) The present cases afford an opportunity to the Central Government, the State Governments and the UTs, particularly the State of Haryana and the GNCTD, to put in place corrective measures.

## Other directions

63. There are certain general directions which also become necessary to be issued. It is made clear that these directions are only to further effectuate the mandatory orders already issued by the Supreme Court from time to time in W.P. (C) No. 196 of 2001 relevant portions of which have already been extracted hereinbefore. These directions are necessary to ensure that the benefits under the various schemes are not denied to the beneficiaries and that assistance is provided promptly at the nearest point where it can be accessed.

64. The health departments of the GNCTD and the State of Haryana will devise formats of registers to be maintained by Medical Officers who are supervising the work of ANMs and the ASHAs. Each ASHA will maintain a proper log of all her visits and have a checklist of the various benefits to be given in terms of the service guarantees of NRHM including ante natal care, essential and emergency obstructive services, referral services, post natal care, child health, family planning and contraception. Each of the visits by an ASHA to a woman during pregnancy and thereafter will be countersigned by an ANM and periodically at least once in 10 days be checked also by the MO.

65. Every ASHA/ANM will report to the MO if any beneficiary is declining the assistance provided or refusing to take medicines or is reluctant to go in for institutional delivery. The MO will then either undertake a personal visit to the woman concerned or issue necessary instructions for further counseling such woman and make a special note thereof in her record. At the District level and thereafter at the State level there must be a periodical review of the performances of the ASHAs and ANMs, district wise. It must be ensured that the cash assistance under the various schemes including the JSY and NMBS is promptly provided to each beneficiary.

66. A review be undertaken of the issuance of AAY card in terms of the orders of the Supreme Court. It should be ensured that every eligible person/family/child is granted the benefit under the AAY.

67. Likewise, there should be a constant review and monitoring under the ICDS as well. This will involve setting up of the Aanganwadi Centers in terms of the directions by these two states for themselves.

68. Ideally special cells have to be set up within the health departments of the Central and State Government for monitoring the implementation of the schemes on a regular basis.

69. The Government of India on its part will immediately issue a corrective to the earlier instructions issued in October 2006 in relation to the JSY as well as instructions relating to the cash assistance under the NMBS so that it is not denied to any woman irrespective of the number of live births or age. There shall be strict compliance of the orders of the Supreme Court in this regard.

…

# Laxmi Singh w/o Manas Ranjan v. State of Odisha & Ors., High Court of Orissa W.P. (C) 7687/2010

## Synopsis

In this case, the petitioner seeks enforcement of the State of Odisha's anti-malaria health plans to protect pregnant women and their infants from malaria infection and related complications.

### Facts

In the rural communities of Orissa, MMR is exacerbated by malaria infection rates at more than double the national average. Pregnant women are twice as likely to be infected as non-pregnant women due to the physiological changes associated with pregnancy. Malaria infection during pregnancy sets off a chain of negative health outcomes including, but not limited to, maternal anemia, spontaneous abortion, still birth, premature delivery, low birth weight, and increased infant mortality.

Worse still, malaria has a disparate impact on poor women and women from Scheduled Castes and Scheduled Tribes because they cannot afford mosquito nets or other preventive measures when the government fails to provide them. The State's failure to protect women from malaria not only violates their rights to health and life, but the socio-economic status aspect of the epidemic also constitutes de facto discrimination.

### Relevant Law

*Constitution*: Articles 14 (right to equal protection), 15 (right to be free from discrimination) & 21 (right to a dignified life)
*Statutes & Schemes*: NRHM, NMBS, National Vector Borne Disease Control Programme (NVBDCP)

## Outcome

Although the High Court at Cuttack disposed of the matter, the case is listed for hearing in late 2012. A team of activists and lawyers has been preparing for the next hearing.

## Order

### March 16, 2012

....

3. The petitioner in this writ petition has challenged the inaction of the opp. parties in taking any step to protect the life of the pregnant woman from Malaria.
4. During the course of hearing, it is brought to the notice of the court that the petitioner has filed a representation dated 15.2.2012 under Annexure-10 before the opp. parties, which is the compliance of Rule-8 of the P.I.L. Rules, 2010.
5. Therefore, at this stage, we direct the opp. parties to consider and dispose of the representation of the petitioner within a period of six weeks from the date of receipt of a copy of this order and report compliance to this Court. It is made clear that no further extension shall be given in this regard.

   With the aforesaid observation and direction, the writ petition is disposed of.

# Mahila Atyachar Virodhi Manch v. State of Rajasthan, High Court of Rajasthan at Jodhpur W.P. (C) 3867/2011

## Synopsis

In *Mahila Atyachar Virodhi Manch v. State of Rajasthan*, the Court took under consideration the tragic and unlawful conditions present at Umaid Hospital, Rajasthan where 28 pregnant women died in less than a month while receiving prenatal care.

### Facts

Between February and March 2011, 28 pregnant women died in less than a month at Umaid Government Hospital in Rajasthan. Their deaths underscored the lack of maternal and reproductive health services offered by the state. A committee of fact-finding investigators visited Umaid Hospital and found unsanitary conditions, denial of free services like blood transfusion and medicine, and an absolute absence of transport for women to and from the Hospital. In Rajasthan, the MMR rests at a staggeringly high 318, which greatly exceeds the national average of 212.[2] Furthermore, Rajasthan is one of 18 states in India classified as a "high focus" state due to its failure to strengthen its poor public health system.

### Relevant Law

*Constitution*: Article 21 (right to a dignified life)
*Statutes & Schemes*: NRHM

## Outcome

The case is still pending.

2 Office of Registrar General, India, Sample Registration System (SRS) on Maternal & Child Morality and Total Fertility Rates, July 7, 2011, http://censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_release_070711.pdf

# People's Union for Civil Liberties (PUCL) v. Union of India, Supreme Court W.P. (C) 196/2001

## Synopsis

*People's Union for Civil Liberties (PUCL) v. Union of India* is a historic, ongoing case, which has affirmed the need for health, food, and shelter as part of the right to a dignified life under Article 21 of the Constitution of India. With respect to maternal health, several orders in this case have underscored the connections between adequate nutrition and the health of mothers and infants. The Court has also given specific directions to the central and state governments regarding the implementation of government schemes including NMBS, JSY, and ICDS.

### Facts

In 2001, during a visit to Jaipur, activists observed that the Food Corporation of India (FCI) godowns were overflowing with grains. The overflow grains were left outside the godowns to rot. Just 5 kilometers away, people were starving; families ate in rotation – one family member would eat one day and others on the next. In 2001, 60 million tonnes of grain were stored in the Food Corporation of India (FCI) godowns, while the buffer stock required was only 20 million tonnes. Despite the fact that the Government had 40 million tones of grain in excess of the buffer stock, people were dying of starvation. It was in this context that PUCL filed a PIL in Rajasthan, which ultimately came to the Supreme Court.

Due to lack of purchasing power, increasing debt, massive unemployment, natural disasters, and other factors, starvation remains a tangible and pressing threat to many in India. According to figures from the Government of India, there are thirty-six crore people living below the poverty line and there are more than five crore people who are victims of starvation. In response, the PUCL sought recognition of the right to food under the Supreme Court in 2001. The petition pointed out that distribution of foodstuffs under India's Public Distribution System (PDS) is irregular and often entirely absent.

### Relevant Law

*Constitution*: Article 21 (right to a dignified life)
*Statutes & Schemes*: AAY, ICDS, JSY, NMBS, PDS

## Outcome

This complex case is ongoing, providing the Court with the opportunity to oversee the government's continued implementation of numerous welfare schemes. Due to the Court's careful oversight, the government has been compelled to ensure functioning Fair Price Shops to provide rations to people living below the poverty line, to construct thousands of anganwadi centres to guarantee basic nutrition and health services to children and pregnant and lactating women, and other much needed schemes. Many of the Court's recent orders focus on the Public Distribution Scheme and the establishment of night shelters for the homeless.

The orders excerpted below focus on the implementation of the NMBS. In one important order, on November 20, 2007, the Court prohibited the government from suspending NMBS. The government had hoped to replace the NMBS with the JSY, which would only provide limited cash transfers to pregnant women having institutional deliveries. In response, the Court ordered that no welfare scheme should be terminated without the Court's prior approval. As such, women are entitled to concurrent benefits under the NMBS and JSY. In addition, the Court expanded the scope of the NMBS, making it applicable to all pregnant women living below the poverty line.

## Orders

### November 28, 2001

…

7. NATIONAL MATERNITY BENEFIT SCHEME (NMBS)
   (i) We direct the State Govts./ Union Territories to implement the National Maternity Benefit Scheme (NMBS) by paying all BPL pregnant women Rs. 500/- through the Sarpanch 8-12 weeks prior to delivery for each of the first two births.
   (ii) It is the case of the Union of India that there has been full compliance of its obligations under the Scheme. However, if any of the States gives a specific instance of non-compliance, the Union of India will do the needful within the framework of the Scheme.

…

### April 27, 2004

… The various schemes for the poorer sections of the citizens of this country have been the subject matter of the orders passed by this Court from time to time. It seems

that some States have discontinued some of the schemes. As an interim measure, till the matter is fully heard in detail, we direct that no scheme covered by the orders made by this Court including…National Maternity Benefit Scheme shall be discontinued or restricted in any way without the prior approval of this Court. In other words, it means that till further orders, the schemes would continue to operate and benefit all those who are covered by the schemes. We hope that the Government of India and the State Governments would simplify the procedure so that high proportion of eligible persons remain to be covered by the schemes.

...

**November 20, 2007**

…

a) The Union Of India and all the State Governments and the Union Territories shall
   (i) continue with the NMBS and
   (ii) ensure that all BPL pregnant women get cash assistance 8-12 weeks prior to the delivery.

b) The amount shall be Rs.500/- per birth irrespective of number of children and the age of the women. (…)

c) All concerned governments are directed to regularly advertise the revised scheme so that the intended beneficiaries can become aware of the scheme.

d) The Central Government shall ensure that the money earmarked for the scheme is not utilized for any other purpose. (…)

e) It shall be the duty of all concerned to ensure that the benefits of the scheme reach the intended beneficiaries. In case it is noticed that there in any diversion of the funds allocated for the scheme, such stringent action as is called for shall be taken against the erring officials responsible for diversion of the funds.

…

# Premlata w/o Ram Sagar & Ors. v. Government of NCT of Delhi, High Court of Delhi W.P. (C) 7687/2010

## Synopsis

This case demonstrates the indivisible link between reproductive rights and the right to food. The six petitioners in this case are pregnant women and new mothers who were denied maternal health services as well as food ration cards. The Delhi High Court passed two landmark orders instructing the government to revamp and publicize the ration card system, and to provide compensation to the women for their injuries.

### Facts

Although the petitioners had ration cards and were entitled to benefits under relevant schemes, they were denied food rations and maternal health care. Some of the petitioners held cards that were pending renewal, and thus could not access rations in the interim. Others held ration cards that were in their husbands' names, but even they were unable to obtain rations. Two were denied cards although they were eligible. They argued that these circumstances interfered with their maternity rights, as the inability to access food affects the vulnerability of a healthy pregnancy and healthy child. Furthermore, the women were not provided with compensation for the institutional births of their children under NMBS and JSY.

### Relevant Law

*Constitution*: Article 21 (right to a dignified life)
*Cases*: *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others,* W.P. (C) 8853/2008; *Jaitun v. Maternal Home MCD, Jangpura & Others,* W.P. (C) 10700/2009 (holding that women have the right to survive pregnancy and childbirth)
*Statutes & Schemes*: AAY, JSY, Ladli Scheme of the GNCTD, NMBS, PDS

## Outcome

Because rations are essential to guaranteeing food and health, essential components of the right to life, the Court declared that the government could not place a cap on the number of ration cards it issues. Therefore, the Court ordered the government to issue ration cards to all eligible individuals.

Even when individuals had valid ration cards, shops often were not open at regular hours or did not provide enough grain at the subsidized rate. The Court emphasized that "poor persons ought not to be denied their entitlement to rations on account of non-functioning of FPSs." Therefore, the Court ordered the government to transfer the petitioners to a functioning FPS until disorganized shops could be brought into compliance. In addition, the Court ordered the Delhi government to set up a "camp" to facilitate issuing and renewing ration cards.

Though in *Laxmi Mandal* the Court held that a woman's age or number of children could not limit monetary payments under NMBS and JSY, the Delhi government had appealed the Court's finding and thus refused to comply. The Court underscored that an appeal did not vitiate the existing decision, and ordered that the women who had not received support under the NMBS and JSY should be provided with cash assistance in the amount of Rs.500/- per birth, regardless of the woman's age or how many other children the woman has. Respondents were ordered to pay additional compensation in the amount of Rs. 5,000/- to each petitioner for causing unnecessary delays in the case.

## Orders

### December 23, 2010

1. A fact-finding was conducted by the learned counsel for the Petitioners by visiting the fair price shop ("FPS") in question at Bhim Nagar on 21st December 2010. The report of the fact-finding together with photographs show that the FPS in question was found closed throughout 21st December 2010. This is contrary to the impression given to the Court on the previous date by the Respondents that the FPSs are normally kept open on all days except a day or two in a month. The photographs reveal the total chaos that prevails in the FPS [when] distributing kerosene oil. It appears to this Court that there is no monitoring by the Food and Supplies Department (FSD) of the GNCTD of the functioning of the FPSs in the area.

2. Mr. Ramesh Chandra, Asstt. Commissioner, FSD who is present in Court, now states that an FIR has been lodged and assures that appropriate orders will be passed in two days transferring the card holders attached to the said FPS at the Bhim Nagar to the closest [alternative] FPS. This Court takes the said assurance on record. It is made clear that if the said assurance is not adhered to, it will be construed as a disobedience of the order of this Court.

3. As regards Petitioner No.1, it appears that her ration card is pending renewal and a biometric review is yet not done. In the meanwhile, she is not being issued rations

…. Petitioner No.1 has seven children and her husband is at work for most of the days. This Court is unable to understand why ration card holder whose card is pending renewal is not issued ration in the interregnum. Further, this is perhaps the plight of others who are awaiting renewal of their ration cards. The Asstt. Commissioner, FSD, who is present in Court, states that a camp … will be held in the Bhim Nagar, Nangloi area on Monday, 27th December 2010 at which the grievances of the ration card holders in the area including those awaiting renewal of their ration cards will be attended to. This will include issuance of new ration cards within ten days subject to compliance of all formalities by the applicants.

…

7. There is a separate issue raised by the counsel for the Petitioners about the entitlements of the Petitioners under the schemes of the Ministry of Health, Union of India as well as the Health Department of the Govt. of NCT of Delhi. These include the National Maternity Benefit Scheme ("NMBS"), the Janani Suraksha Yojana (JSY) Scheme, the Antyodaya Anna Yojana (AAY) schemes of the Government of India and the Ladli Scheme of the GNCTD. … Ms. Sindhwani states that a detailed review will be undertaken whether the Petitioners have been afforded all benefits under the schemes or not. An additional affidavit in this regard will be filed by the [Union of India and] GNCTD within three weeks.

…

9. This Court is of the view that the monitoring of the functioning of the fair price shops has to be tightened and poor persons ought not to be denied their entitlement to rations on account of non-functioning of FPSs. The Asstt. Commissioner, FSD states that a special task force will be set up within the next three days to undertake an intensive survey of the FPSs in the Nangloi Circle on a continuous basis for the next 10 days thereafter. A status report will be filed in this regard before the next date of hearing. Wherever any corrective action is required to be taken, it will be taken without awaiting further orders of this Court. The purpose of this survey is to ensure that the FPSs function in a proper manner and the card holders are not deprived of the rations and other benefits to which they are entitled.

**February 2, 2011**

1. A detailed order was passed by this Court on 23rd December 2010 in regard to the functioning of Fair Price Shops ("FPSs") in the Bhim Nagar area. Learned counsel for the Petitioners have thereafter undertaken a fact-finding by visiting Bhim Nagar on 13th and 21st January 2011. They have placed on record a fact-finding report

… [that] raises a large number of issues including the recommendations made by the Committee appointed by the Supreme Court headed by Justice D. P. Wadhwa, retired Judge of the Supreme Court, in relation to the public distribution system in Delhi. …

7. A further aspect concerns the entitlements of the Petitioners to the benefits under the National Maternity Benefit Scheme ("NMBS") and the Janani Suraksha Yojana ("JSY"). … It appears further from the submissions of Dr. Neelam Bhatia, CMO (NFSG), JSY Nodal Officer for West District that although the IDHS received a copy of the order of the Supreme Court clarifying that the benefit is available under the JSY to women beyond the second child, consequential directions have not been issued by the Central Government, which is the grant making authority. Learned counsel appearing on behalf of the Union of India, Ministry of Health and Family Welfare, Respondent No. 5, states that a response will be filed by that Ministry to the said affidavit of Dr. Dharma Prakash within two weeks. It is directed that the affidavit be filed by a person holding the rank of not lower than a Joint Secretary. The said affidavit should indicate the reasons for not issuing directions in light of the orders of the Supreme Court.
…

**February 21, 2011**

1. Pursuant to the order dated 14th February 2011, an affidavit has been filed by the Additional Commissioner, Food and Supplies Department ("FSD"), GNCTD enclosing an updated action taken report on the Justice Wadhwa Committee's recommendations. ...

8. As regards, the disbursal of cash assistance under the National Maternity Benefit Scheme ("NMBS"), this Court is not satisfied with the affidavit dated 14th February 2011 filed by Ms. Anuradha Gupta, Joint Secretary, Ministry of Health and Family Welfare, Government of India. Merely because the Union of India has filed an IA in the Supreme Court seeking modification of the order dated 20th November 2007, it does not entitle the Union of India, unless the said order is modified, to disobey the said order which makes it absolutely clear that the cash assistance of Rs.500/- per birth is irrespective of number of children and the age of the woman. This has also been reiterated by this Court in Laxmi Mandal v. Union of India 172 (2010) DLT 9

9. Counsel for the Union of India states that he will seek further instructions. The concerned Joint Secretary will also remain present in Court on the next date of hearing.

**May 13, 2011**

2. A reply has been filed by Respondent No. 1 GNCTD to CM Application No. 6265 of 2011 stating that the grievances of the Petitioners have more or less been resolved. Nevertheless, learned counsel for the Petitioners has pointed out that the issues that require to be addressed.

3. It is stated by Respondent No. 5, Union of India ("UOI"), that pursuant to the orders dated 21st February 2011 and 18th April 2011 costs of Rs. 5,000/- have been paid to each of the Petitioners. Also cash assistance of Rs. 500/- per live birth has been paid to each of them under the National Maternity Benefit Scheme ("NMBS"). A copy of letter dated 21st April 2011 of the Ministry of Health and Family Welfare, RCH Division addressed to the GNCTD that "payments are to be made under JSY component of RCH programme", has been placed on record.

4. Ms. Ritu Kumar, learned counsel appearing for the Petitioners points out that this is not in compliance with the orders of the Supreme Court passed on 20th November 2007 in terms of which, according to her, the benefits under both the NMBS and the Janani Suraksha Yojana ("JSY") would be available to the Petitioners. Mr. A.S. Chandhiok, learned Additional Solicitor General ("ASG") appearing for the UOI informs the Court that the application filed by the UOI seeking clarification of the aforesaid order of the Supreme Court was mentioned before the Supreme Court. The learned ASG states that the Supreme Court requested that this Court should take up this issue after the Supreme Court hears the said application on 21st July 2011.

5. In view of the aforesaid statement made by the learned ASG the consideration of the issue concerning NMBS is deferred till the next date of hearing.

6. The second issue concerns the Janani Suraksha Yojana ("JSY") Scheme. In particular, it is pointed out that Petitioner No. 4 has been given cash assistance only in respect of one child. Ms. Ruchi Sindhwani, learned counsel appearing for the GNCTD states that necessary orders will be issued to enable Petitioner No. 4 to get cash assistance for the second child also. This should be done within four weeks from today.

…

# Promotion and Advancement of Justice, Harmony, and Rights of Adivasis (PAJHRA) v. State of Assam, Gauhati High Court W.P. 21/2012; Supreme Court SLP 15555/2012

## Synopsis

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.

### 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.[3] A 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.

### Relevant Law

*Constitution*: Articles 21 (right to a dignified life)
*Statutes and Schemes*: NRHM, The Plantations Labour and Tea Plantation Laws, 1956

## Outcome

The Court disposed of the case on March 27, 2012, "hop[ing] and trust[ing] that the concerned authorities will perform their duty sincerely in implementing the scheme which provides access to basic health services for most disadvantaged sections of society." Unsatisfied with the High Court's judgment, HRLN and PAJHRA filed a Special Leave Petition in the Supreme Court requesting the apex court to examine the matter.

3 Office of Registrar General, India, Sample Registration System (SRS) on Maternal & Child Morality and Total Fertility Rates, July 7, 2011, http://censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_release_070711.pdf

## Orders

### March 27, 2012

…
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.

# Sandesh Bansal v. Union of India, High Court of Madhya Pradesh at Indore W.P. 9061/2008.

## Synopsis

Here, the High Court of Madhya Pradesh unequivocally affirmed women's right to survive pregnancy and childbirth. The High Court found that the state has an obligation to protect pregnant women from dying of preventable causes. This right falls within the right to health, which is itself a fundamental right that forms an essential part of the right to life under Article 21 of the Constitution of India.

### Facts

This PIL underscores the conditions underlying the high rate of maternal mortality and morbidity in Madhya Pradesh (MP). In MP, over 400 maternal deaths occur per 100,000 live births – far above the national average, which was reported as 254 per 100,000 live births for the years 2004–2006.[4] In some of the poorest districts of MP, the MMR soars as high as 800 in 100,000. In spite of the State's Programme Implementation Plan (PIP) for the NRHM, pervasive and systemic problems persist in the delivery of maternal care.

Fact-findings by the Petitioner, Sandesh Bansal, and the HRLN team illustrate that due to the lack of functional infrastructure, skilled staff, and adequate resources, which is further compounded by health care providers' outright negligence, pregnant women in MP continue to die of preventable causes including anemia, hemorrhage, and sepsis. HRLN and the Petitioner filed this PIL demanding that the government properly implement government welfare programmes, particularly the PIP and NRHM, by providing pregnant women with appropriate health care and that it also make a concerted effort to reduce its MMR.

### Relevant Law

*Constitution*: Article 21 (right to a dignified life)
*Statutes & Schemes*: NRHM

4 Office of Registrar General, India, Sample Registration System (SRS) on Maternal & Child Morality and Total Fertility Rates, July 7, 2011, http://censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_release_070711.pdf

## Outcome

Although the State of Madhya Pradesh submitted affidavits representing that all state-run hospitals and health centres were adequately staffed, the Court's self-initiated investigation of three randomly selected facilities revealed conditions far inferior to those asserted by the State. The Court's detailed investigation documented a shortage of staff, inadequate opening hours, and a lack of proper water and electricity, among other problems.

According to the Court, these failures have resulted in an increased risk of maternal mortality and morbidity for women in Madhya Pradesh. Under Article 21 of the Constitution of India, "the State of Madhya Pradesh is under [an] obligation to secure [women's] li[ves]." Thus, the government must ensure adequate health care facilities and staffing so that women do not suffer death or disability from preventable complications related to pregnancy and childbirth.

To remedy the shortcomings revealed by the Court's investigation, the Court gave orders with respect to the staffing and functioning of MP's health facilities to remedy the gaps in the government's own mandated standards under the PIP. The government was ordered to make its best efforts to bring its MMR down to 100, from over 400, by 2012 as specified in the PIP.

## Orders

### August 9, 2011

Counsel appearing on behalf of respondent No.1 submitted that his Senior Shri Mohan Sausarkar has gone to Delhi and prays for short adjournment. Shri Rahul Jain, learned Dy.A.G. also ...prays for two weeks time.

Prayer is opposed by the counsel for the petitioner who submitted that more than 16 adjournments have been granted in this case but in spite of this respondents have not filed reply, rather a proper reply in this matter. It is also submitted by her that this case was fixed today with the consent of the parties and in case of adjournment, a heavy cost be imposed on the respondents because only to argue this matter, she has come from Delhi.

Though the aforesaid contention is opposed by the respondents but we found substance in the objection of the petitioner. As the counsel for respondent No.1 is not appearing and State has not filed proper reply, we adjourn hearing of this matter for a period of

2 weeks as prayed by Shri Rahul Jain, however, on payment of cost which we quantify Rs.10,000/-payable by both the set of the respondents in equal share. …

**October 10, 2011**

Due to non[-]filing of the reply/explanation, this Court by order dated 9.8.2011 imposed cost on the Union of India and State of Madhya Pradesh of Rs.5000/- each. ...

It is stated by the Union of India that the explanation was already filed on 10.11.2009[,] so there was no question of imposition of cost. However, along with this reply the Union of India has filed an affidavit of respondent No.1 in respect of the quarries earlier raised by this Court.

So far as the respondent No.2 to 5 are concerned, they have explained that the O.I.C. Dr. Shafatullah was sick and admitted in the hospital between 5.8.2011 and 10.8.2011, so the return could not be filed in time and on these grounds, the respondents have prayed for waiver of the cost. …Though it is tried to explain that there were some reason of non-filing of reply by the State on or before 9.8.2011 but no affidavit or documentary evidence is produced along with the application to show that in fact O.I.C. was admitted in the hospital. Similar is the position with the Central Government, …but in fact on 9.9.2011 an additional affidavit on behalf of respondent No.1 was filed in response to the quarry which were raised by this Court. In these circumstances, we do not find any justification in waiving the cost. …

## Judgment

In respect of health care time is the essence, because if the timely care is not taken any amount of care later on will not compensate the loss which may occasion due to lack of timely medical assistance. If this is true in case of critical disease, equally true it is in respect of an expecting mother. Who though go through a natural process in delivering a child, but because of lack of pre-assistance suffers [casualties] accounting for 40 per 1,00,000 live births, which is on the higher side in Rural than Urban areas.

2. Alarming mother mortality ratio (MMR) paved the way for launching of National Rural Health Mission (in short Mission) by the Central Government, which was in furtherance of its primary duty to improve public health being one of the Directive Principles of the State Policy as enunciated under Article 47 of the Constitution of India, in the year 2005 to meet out peoples' health needs in rural areas.

3. The Mission seeks to provide accessible, affordable, and quality health care to the rural population. It also seeks to reduce the Maternal Mortality Ratio (hereafter shall be referred to MMR) in the country from 407 to 100 per 1,00,000 births by focusing on the following measures: [See introduction to book for discussion on NRHM]

   …

5. In Madhya Pradesh, the Mission as set out by the … Government of India and a Programme Implementation Plan 2006-2012 has been mooted out by the State Health Mission… with an object that all people living in the State of Madhya Pradesh will have the knowledge and skills to keep themselves healthy, and have equity in access to effective and affordable health care, as close to the family as possible, that enhances their quality of life, and enables them to lead a health productive life.

6. The Programme Implementation Plan aims at equipping people with knowledge and skills required to keep themselves healthy, provide effective health care to rural population throughout the State with special focus on worst performing districts, which have weak public health indicators and/or weak infrastructure. These districts are Dindori, Damoh, Sidhi, Badwani, Anuppur, Chhindwara, Rewa, Betul, Raisen, Seoni, Chhatarpur, Morena, and Sheopur.

7. While implementing the mission it was noted that (i) Districts Chhartpur, Guna, Satna, and Sidhi have more than 40% pregnant women with no ANC (Ante Natal Care) check-ups and 32 districts have less than 40% pregnant woman with 3 ANC check-ups; (ii) T.T. coverage is less than 50% in districts Dindori, West Nimar, Sidhi, Sheopur, Shahdol, Panna, and Jhabua; and (iii) Institutional deliveries less than 20% in Chhatarpur, Dindori, Katni, Shahdol, Sidhi, and West Nimar.

8. While setting the goal of reducing the State MMR from 498 to 200 by the year 2010 the PIP identified the following key elements:
   (a) Access to emergency obstetric care
   (b) Skilled attendant at birth
   (c) Effective referral system

The strategy included:

(i) To operationalize minimum of 2 Comprehensive Emergency Obstetric Care and Neonatal Care (hereinafter referred as, "CEmONC") facilities & minimum 4 Basic Emergency Obstetric and Neonatal Care (hereinafter referred as, "BEmONC") facilities in a district.

(ii) To provide incentives to doctors and other health providers to ensure their presence in facilities for 24 hrs delivery service in all BEmONCs and other PHCs where facilities for essential obstetric care is existing.

(iii) To improve access to skilled delivery care and emergency obstetric care.

(iv) To reduce maternal morbidity and mortality due to post partum haemorrhage by active management of third stage of labour.

(v) To improve coverage and quality of antenatal care by ensuring effective and quality ANC services through fixed day (Friday) clinic approach with focus on women of BPL/SC/ST, primigravidas and adolescent mothers.

(vi) Providing mobility support to ANM and cash incentive to ASHA/Dai for mobilizing women for Antenatal & Postnatal check-up.

(vii) Introducing uniform Obstetric record card in all health institutions where Antenatal & Postnatal check-up are being done by doctors.

(viii) Ensuring availability of skilled birth attendants by training of medical officers, staff nurses and ANMs in quality antenatal care.

(ix) Posting of one additional ANM on contractual basis in all sub-health centers.

(x) Ensure adequate availability of Uristicks & SAHLIS charts at each sub-health centers to identify high risk pregnancies.

(xi) Provide pregnant women with double fortified salt to prevent anaemia, as well as with folic acid and multivitamins and supplementing calcium.

(xii) To improve coverage and quality of postnatal care by incorporating postnatal visits 6-12 hours, 3-6 days, 6 weeks and 6 months after delivery.

(xiii) Postnatal care will be provided through ANM, Anganwadi workers and ASHA in cases of domiciliary deliveries within first two days delivery.

(xiv) Fixed day approach for postnatal Clinic on Friday to be linked with Antenatal clinic.

(xv) Ensuring three days stay in institution post delivery.

(xvi) To increase number of quality of institutional deliveries.

(xvii) To improve the access of safe abortion service.

(xviii) To mobilize community for availing referral transport services and delivery in institution.

(xix) To ensure Medical Termination of Pregnancy by MVA technique for abortion in all BEmONC facilities.

(xx) To provide essential equipments & drugs for providing Comprehensive Abortion Care to the identified centers.

9. Besides above, the Programme Implementation Plan aims at-
   (a) Strengthening infrastructure by undertaking minor repair/renovation of operation theaters, labour-room and Maternity Wards in Comprehensive Emergency Obstetric Neonatal Care (CEmONC) and Basic Emergency Obstetric Neonatal Care (BemONC) facilities.

   (b) Undertake human resources interventions and as taking specialists and other persons as required or contract providing special training in Emergency Obstetric Care and Life saving Anesthetic skill as required to fill gaps, training for blood transfusion and storage facilities.

   (c) Ensure that CEmONC's have adequate facilities to provide all services including blood.

10. Alleging failure of effective implementation of the modalities set by PIP 2006-2012 and achieving the goal as set by it to reduce the MMR, the petitioner, a social activist and a Member/State Coordinator of Madhya Pradesh Jan Adhikar Manch - a network of civil society organisations/NGOs in Madhya Pradesh working on raising concern over the high maternal mortality in the State of Madhya Pradesh, as a part of their 'Save our Mothers' campaign has filed this petition alleging that about 75,000 to 1,50,000 women die every year in India after giving birth to their child. It is said that this is about 20 % of the global burden. It is further contended that Madhya Pradesh has the third highest maternal mortality rate in the country, i.e., 498 deaths per 1,00,000 live births. It is contended that there is imbalance within the State itself as though the average MMR is 498 per 1,00,000; however, in Chambal region the MMR is as high as over 800 deaths per 100,000 live births. It is urged that anaemia is the underlying cause in over 50% of these deaths. Other major

causes include haemorrhage (both ante and post partum), toxemia (Hypertension during pregnancy), obstructed labour, puerperal sepsis (infections after delivery) and unsafe abortion.

11. It is contended that women are dying because of the high cost of health care and failure of public health system, lack of qualified medical staff in rural areas, lack of appropriate transport, cultural and social reasons that come in way of women for effective and adequate access to health care. By way of example, it is stated that a mother from the richest 20 % of the population is 3.6 times more likely to receive antenatal care from a medically trained person, compared to a mother from the poorest 20%. The delivery of richer mother is over six times more likely to be attended by a medically trained person, than the delivery of the poor mother.

12. Placing reliance on the appraisal report of Common Review Mission (The CRM was set up as part of Mission Steering Groups mandate of review and concurrent evaluation) of November 2007, it is contended that there are inadequate institutional deliveries in the State of Madhya Pradesh because of lack of quality services, indifference of Rogi Kalyan Samiti towards patient welfare, early discharge patient care, misuse of Janani Suraksha Yojna (JSY). It is alleged that in respect of Antenatal Care, Intra-Natal Care (24 hours delivery services both normal and assisted) and Postnatal Care, the State of Madhya Pradesh has failed to adhere the norms set by Indian, Public Health Standards for Primary Health Centres (PHC's).

13. It is contended that the mission being centrally sponsored, the funds are made available by the Central Government [This fact is substantiated by the Central Government through the return filed by them that being centrally sponsored scheme funds are regularly released (four years figures are given that in 2005-06 Rs.28.29 crores, in 2006-07, Rs.258.22 crores, in 2007-08, Rs.880.17 crores and in 2008-09 Rs.1241.35 crores were released)]. It is alleged that the mission has failed to achieve the goal because ineffective implementation of the plan.

14. It is stated that no District Health Mission has been constituted in the State of Madhya Pradesh under the Mission which has resulted in non survey of household and the facility to measure the progress which in turn has resulted in non-formulation of perspective plans for Districts (though there exists perspective plan for the State). Non formulation of District and Block level Community Monitoring Committees, Non-holding of Jan Sunvayi at Block and PHC level. It is contended that only 31.43% of villages in state have Village Health and Sanitation Committee. That 279 out of 870 Rogi Kalyan Samitis are not set up at PHC level. Non contribution in

State budget for the PIP during 2007 - 08 (as against the 11th 5 year plan's mandate for Contribution of 15% of their budget to the mission). Non utilization of the fund. Over-expenditure on management then prescribed by the mission at 10.29%. Diverting the fund (it is alleged that Rs.52.07 crore of Mission Flexipool has been diverted to RCH Flexipool). Non utilization of Rs.6357.31 lakhs at District level. Other shortcomings pointed out are:

- "In MP, state bank accounts were not opened for VHSC funds.
- There was a wide difference between the funds released by the Ministry and the funds received by the SHS's in 2005 - 06 the difference was- 126.85 crores and 90.72 in 2006-07.
- In MP, some CHC's and PHC's cash books and ledgers for the year 2006-07 were not maintained.
- Also, Original vouchers worth Rs. 125.15 lakh (out of Rs.340.41 lakh) for the year 2006 -07 by the DHS Bhopal and vouchers for Rs. 59.70 Lakhs and Rs.439.27 lakh for the year 2005-06 and 2006-07 respectively by the DHS Morena were not produced to the chartered accountants for audit.
- In MP, cases of delay in Civil works were found. Only four works of Rs. 46.71 lakh had been completed and handed over out of the 94 works for which advances were given to the government agencies.
- Also, cases of irregularities were found in execution of the Civil works. In 90 works advances were not adjusted/recovered from the government agencies, viz. PWD and RES. State Governments were to contribute 25% of the cost of creation and upgradation of the infrastructure for the Sub Centres. During 2005-08, MP was one of the defaulters of the same among 9 others.

- The required number of health centers at each level as was required per population did not exist.
- The Mission targeted creation of 30percent of the proposed new infrastructure by 2007, however, during 2005 -08 M.P. did not take up the work of setting up new infrastructure. There were cases of irregularities in execution of Civil work as well. In Madhya Pradesh, in 90 work advances were not adjusted/recovered from the government agencies, viz. PWD and RES. According to NRHM guidelines, all States were required to create a target number of health centres. In MP, there is a short fall of 1309 SC's, 487 PHC's and 66 CHCs' also the infrastructure which was required to be created by 2007 included 393 SC's 146 PHC's and 20 CHC's, none of which have been created by the State.

- With respect to the condition of buildings, MP has 46 Sub Center which operate without a building, 24 Sub Centres and 8 PHCs' which run without a government building, and 36 SC's and 10 PHC's operating in dilapidated buildings.

- The auditors report on hygiene and sanitation shows that 30 SC's, 5 PHC's and 1 CHC's operate as Health Centre with bad milieu/surroundings. Further 10 SC's, PHC's and 4 CHC's have poor cleanliness. There also exist 70 SC's, 25 PHC's and 6 CHC's that have no separate utilities for men and women. Absence of sewage have also been observed in 35 SC's and 12 PHC's.

- Inadequate infrastructural support to health center has adversely affected the quality of health care to the rural population. In MP,70 SC's, 28 PHC's and 1 CHC run without a telephone. There are 22 SC's which operate without electricity. Also, 26 PHC's and 4 CHC's do not have a vehicle and 35 PHC's do not have a computer.

- TB diagnosis facilities were also found not available into 2 CHC's and 98 PHC's of a few State of which M.P. was apart. In MP, it was observed that none of the health centers had adequate supply of Kit A and Kit B and only 6 CHC's had facilities for cesarean section.

- With respect to the status of cold chain equipments in CHC's, out of 18 audited CHC's, only 15 had ice lined freezers and 13 had refrigerators. None of the PHC's had such equipment.

- Each Sub Centre under the NRHM was to be run by two Auxiliary Nursing Midwives (ANM, female). Most of the Sub Centres in MP did not have these ANMs.

- 100% SC's with Two ANM's, 16% SC's with one ANM and 66% SC's with MPWs operated without the prescribed staff.

- In MP, none of the test checked centres had an AYUSH doctor.

- Also, none of the sampled PHC's had three staff nurses.

- In MP, 89% CHC's were without general Physicians, Paediatrician and General Surgeons, 83% CHC's were without Obstetrician Gynaecologists and 100% CHC's were without an Anaesthetist.

- All the test checked CHC's had less than 9 Staff Nurses in MP.

- With respect to CHC's without prescribed staff, in MP 100% were 9 staff nurses, 89% were 5 staff nurses, 6 % were 1 staff nurses, 33% radiologists, 28% pharmacists, 6 percent Lab Technicians.

- A shortfall was notified in the appointment of contractual staff vis-a-vis targets set under the PIPS'
- Among other states in MP, 29-57% of the contractual staff left before the completion of their contract period. MP did not set up state PMSU's.
- At the District level, three essential management personnel viz. Programme Manager, Accounts Manager and Data Manager were yet to be appointed at the DPMSU in MP.
- Similar was the case at the block level where PMSU's were partially set up.
- MP did not have all the five modules of induction training which is given to all the selected ASHA's for eg. In MP, only 24% had training upto the 4th module.
- In MP there was a difference of 260 between the SHS and DHS data with respect to the number of ASHA's engaged in audited districts.
- Similar was the discrepancy between the SHS and DHS datas with respect to the training of ASHA's the difference was -697, -1217, -1077 and -1301 relating to modules 1,2,3 and 4 respectively.
- All organizations were required to prepare codified purchase manuals, containing detailed procedures. However, in MP, the SHS's had no documented written procedures and practices and procurement.
- In MP., with respect to cases of excessive and infructuous purchases ASHA kits were procured in excess of requirement resulted in excessive expenditure worth Rs.73.49 lakh.
- With respect to utilization of funds released for procurement at SHS's in MP during 2005-08, the percentage of unspent amount equalled 17.94%.
- During 2006-07, SHS released Rs.889 lakh to the IEC Bureau. The IEC Bureau however, had shown the receipt of 697.08 lakh and the remaining could not be reconciled. Irregularities amounted to 1.92 crores.
- The SHS of MP, however, did not furnish information on VHND's and/or school health check ups.
- The district is the basic unit for all interventions under the NRHM. However, the district wise long term targets for impact indicators and annual targets for performance indicators were also not prescribed in MP.

- With respect to the Status of registration and ante natal check ups of pregnant women, in MP during 2005-08, 55% of the women were not registered within 12 weeks of pregnancy. Also the percentage of women who received four Ante Natal Checkups (ANC) was only 45%. Also, the percentage of women who did not receive any ANC at all was 21.71%.

- A majority of the pregnant women were registered but did not use the health centres for institutional deliveries.
- In MP, the payment to cash beneficiaries was delayed for periods ranging from 8-730 days.

In MP, payment of Rs.0.58 lakhs in Lakhanadaon CHC of Seoni district made in 35 cases under the JSY were doubtful as the names of the patients were different in the payment register and IPD register against the same IPD nos. also, the expenditure on cash incentives under the JSY increased from Rs.49.60 crore in 2006-07 to Rs.194.31 crore in 2007-08 and beneficiaries increased from 3.97 lakh to 11.06 lakh for institutional deliveries while as per IPD figures provided by the SHS, number of in-patients were 2.60 lakhs in 37 out of 48 districts in 2007-08.

In 34 **districts** sampled, out of which MP was a part, it was found that amounts equalling 57% **released for** referral service remained unutilized.

With respect to maternal deaths, **in** MP, there was no prop**er** mechanism to get regular information about maternal and neo natal deaths from post partum centres.

In **MP,** there was a shortfall of 32% from the **target** set under the sterilization during 2005-08."

15. With these surmounting shortcomings the petitioner alleges ineffective implementation of plan and alleges lack of will in the functionaries of **the** State to meet out the goal of **reducing the** MMR. **It** is urged that the State Government be therefore directed to take effective steps to reach the goal **of r**educing the MMR within the targeted period.

**16. The respondent** State of Madhya Pradesh while admitting the **fac**t that **facilities in** the Government Hospitals were not proper, and not disputing the applicability of **Indian Public** Health Standard Guidelines and the Operational Guidelines on Maternal and Newborn Health prepared under the National Rural Health Mission (paragraph 3 of th**e** return), have **to** submit that with the available economic resourced and the skilled man-power efforts **are made to** meet out the objective

and the goal set out by **the** Mission. It is further contended that because of the concrete efforts the MMR in the State **of** Madhya Pradesh has **come** down to **310** per 1,00,000 **live** in the year 2010 as against 448 per 1,00,000 in the year 1997(this aspect however has been disputed by the **petitioner stating** the less figure has been shown by accounting the deaths because of loss of blood and haemorrhage). It is urged that the circulars have been issued for making all the health centres operational by the year 2012 and phase wise programme has been made to implement it in whole of Madhya Pradesh. Regarding transport facility, it is contended that the State Govt. brought into existence Janani Express Yojna in the year 2006 where under 2 to 3 Janani Express Vehicle has been made available in every block and instructions have been issued to make it available within one hour of receiving the call. It is contended that Auxiliary Nurse Midwife (ANM) has been appointed for every Sub-Health Centres and is being trained to cater the medical need of pregnant lady of the area wherein she is posted. It is contended that every care is being taken of the pregnant lady of rural area and immediately after registration of pregnancy the check up is being done by the ANM and in case of any complication she is required to get her checked from a qualified doctor and during the entire pregnancy they are checked four times of which once is by a doctor. (thus, there appears to be no regular check up by the qualified lady doctor).

17. At this stage we take note of the facts in respect of the fund allocation by the Central Govt. and the number of PHC/CHC and District Hospitals in the State of Madhya Pradesh.

18. In an affidavit dated 22-2-2011 filed by the Director, Public Health and Family Welfare, Govt. of M.P., Bhopal, it is stated that the State Govt. has received amount from the Central Govt. in RCH (Reproductive Child Health) and NRHM (National Rural Health Mission) Schemes. Under NRHM amount of Rs. 944.44 lakhs was received in the year 2005-06 out of which Rs. 3860.17 lakhs were spent in the year 2007-07 against the amount Rs. 22,832.95 received, Rs. 17153.52 lakhs were spent. In the year 2007-08 amount of Rs. 44064.08 against Rs. 47279.50 was spent. For the year 2008-09 against the amount of Rs. 47894.77 lakh Rs. 47330.35 has been spent. It is stated that at the end of 2008-09 Rs. 17127.01 lakh remains unutilized. Regarding Health Centres the affidavit dated 6/9/2010 spells out that in the State there are 1115 PHCs, 333 CHCs and 50 District Hospitals. In respect of man-power and the infrastructure, neither the return nor the affidavit speaks much about the same. No definite figures have been given as how these PHCs/ CHCs and District Hospitals are armed with skilled personnel and whether these Medical Centres are well equipped to meet out their exigencies for which they are established. Though through an affidavit filed on 15-12-2008 it is stated that in the

State of Madhya Pradesh the system is evolved that District Hospitals are made to function at district level, community Centres at Block levels. Primary Health Centres through Sub-Centres to serve 5 to 7 villages. It is further contended that in District Hospitals there exist definite strength of Doctors (31-35), Compounders (8 to 10), Staff Nurse (20 to 30), ANM (10 to 15), LHB (2 to 3), Ayah (8 to 10), Ward Boy (20 to 30), Driver (8 to 10), Other staff (15 to 20). At Block level: Doctors (5), Compounders (2), Dresser (1 to 2), Driver (1 to 2), ANM (2 to 3), Lady Health Visitor (1 to 2), Staff Nurse (1 to 2), Ward Boy (3 to 4), Accountant (1), Compounder (1), Radiographer (1), Lab. Technician (1 to 2). At PHC and Sub-Centre level MPs(l), Clerk (1), Sweeper (2). At Primary Health Centres : Doctor (1 to 2), compounder (1), Dresser(1), ANM(l), LHV (1), Ward Boy (1), Sweeper (1),Multipurpose Worker male (1). Ast Sub Centres multi purpose (M) Worker (1), multi purpose worker (F) (1).

19. Though these figures are given, but the District /CHC/ PHC/Sub Centre wise Break up has not been given to meet out the allegations that these Health Centres are not taken care of.

20. In order to test the correctness of what has been said by respondent State of M.P and its functionaries as to availability of the staff and facilities in health centres we randomly selected the two PHCs and one sub centre in the Gwalior Region, viz, Primary Health Centre Bijora and Surpura and Sub-Health Centre Kishupura and got the same inspected through Registrar Gwalior to have first hand information. The report furnished on 28.1.09 reflects dismal conditions far from what is pointed in the return and the affidavit.

21. We consider it proper to reproduce the entire report as we are informed that the conditions of other centres in the State is none the less better. The object of reproducing the report is to enable the State Government to address to the short comings.\

…[Court had included a table of the staff who were posted at the facilities and those present on the day of the investigation]

## DISTANCE FROM MAIN ROAD

The Distance of Primary Health Centre Surpura is only 4.5 kms away from the Surpura Village.

## INFRASTRUCTURE

The PHC of Surpura is BEMOC-PHC and in this health centre here are about 9 rooms. There are 4 beds for the patients in the ward and one bed is in the duty room. One dark room, one labour room, one vaccination room, and a pathology lab is there in this health centre. The building is also secured by a boundary wall. Two 'H' Type staff quarters are there adjoining the health centre, but are in dilapidated condition and since the quarters are not secured by a boundary wall, the same are not safe for living. Child weighing machine, mother weighing machine and other essential equipments are available in the Surpura health centre. There is adequate stock of medicine etc. This centre has the facility of normal delivery & prenatal and post natal Clinic facilities. It has proper facility of let-bath for the patients. In this centre 24 hours staff is available which is evident from the duty chart available, although doctors are not available at night hours.

## AVAILABILITY OF ELECTRICITY

PHC at Surpura has electric connections [and fittings] in all its rooms but it has been informed that since the last two years there has been no electric supply in this village, therefore, this centre runs without light. … For serving the purpose of light gas patromax is available but no facility of generator is there. …[A] transformer of 100 KVA installed at village Surpura has gone out of order on 23-4-08 and a sum of Rs. 22,22,224/- being outstanding against the consumers on this transformer, the electric company cannot change the transformer. Therefore, supply of electricity is disrupted. A campus was organized on 17.1.09 in which none of the consumers deposited any amount outstanding against them. Therefore, it is not feasible to continue electric supply. …

## AVAILABILITY OF WATER

In the premises and building of Primary Health Centre, Surpura even though the water connection fittings have been made but water could not be made available as the first boring which was got done failed and the work of second boring was in progress when we inspected the centre. The arrangement of water is done from outside the health centre by engaging labours.

## MEDICAL FACILITIES AVAILABLE

In the PHC of Surpura lab facility with essential equipments and a Lab technician who performs essential pathological tests are available here. In this centre delivery facility is told to be available 24 hours and in the absence of electric supply gas petromax is

used. In this centre although various machines & instruments have been made available but are lying useless for non-availability of power. For eye examination there is an Eye Assistant as well as one dark room is also available. In perspective of the … "Janani Suraksha Yojna" help of Rs. 1400/- is given to the Beneficiaries and under … "Aasha Prerak Yojna" who motivates the beneficiary is given help of Rs. 350/- in two installments, the proper record/accounts of which is maintained in the hospital. The ambulance meant for Janani Suraksha is also available at the mobile phone call from Atter PHC, which was got examined by making a call at the mobile phone, displayed in the campus. Vaccination facilities for pregnant women and infants are also available at the centre. All the records have been properly maintained. In the display board at the Centre the names of the doctors, duty hours, Janani Suraksha Ambulance Number etc. are displayed.

At this centre proper facility of prenatal and postnatal check up and vaccination etc. are available and proper record is being maintained.
The villagers gathered at the time of inspection has demanded the duty of doctors at night also.

Sub Health Centre Kishupura

……[Court had included a table of the staff who were posted at the facilities and those present on the day of the investigation]

## DISTANCE FROM MAIN ROAD

The Distance of Primary Health Centre Kishupura is only 5 kms away from the Surpura PHC.

## INFRASTRUCTURE & FACILITIESAVAILABLE

The Sub-Health Centre of Kishupura is situated within two rooms. Over here the pregnant women and new born child can avail the facility of medicines like vitamins, iron, folic acid, ORS and some essential medicines for vomiting and diarrhea are also available. Facility of vaccination, weighing machine of/ child and mother is made available at centre. In this centre even though Blood Pressure Instrument is available but when the MPW Female was directed to measure the BP, she was unable to check BP properly. In this Centre there is only facility of hemoglobin tests on the hemoglobin test paper. This centre is not functional on all days of the week, it opens only once a week i.e. Every Thursday and on the rest week days the Female MPW (Multipurpose

worker) has to make visit of the nearby villages allotted to her. It has been informed that since no adequate arrangement of stay is available at this health centre, she lives in the nearby village and as per the scheduled programme she takes round and provides various services eg. Educating the pregnant women, vaccination and distribution of iron and folic acid tablets & vaccination of infants etc., to all the seven villages allotted to her. But it has been informed by the villagers that most of the facilities of medicines and other instruments which were available at the health centre has been made available in the last two days only. The mobile number of Janani Suraksha Vehicle is displayed in the campus of this centre. Facility of let-bath is not available at this centre.

## AVAILABILITY OF ELECTRICITY

There is no electric facility in this sub- centre. They work only in the light of candles, though it has been reported that this sub- centre is not functional at night.

## AVAILABILITY OF WATER

For meeting out the water facility of this Sub-Centre one hand pump is available in the premises.

## AVAILABILITY OF DOCTORS AND STAFF

In the Sub-Centre of Kishupura the post of MPW (Male) is lying vacant and only MPW (Female) /A.N.M. Smt. Devkumari Bhadoriya is posted.

## MEDICAL FACILITIES

The Villagers gathered at the Sub-Centre Kishupura have demanded that the sub-centre should remain functional on all days with sufficient medicine and at least availability once a week the facility of doctors should also be made available at this sub-centre…

We don't wish to burden our order with further facts. But we observe from the material on record that there is shortage not only of the infrastructure but of the manpower also which has adversely affected the effective implementation of the Mission which in turn is costing the life of mothers in the course of mothering. It be remembered that the inability of women to survive pregnancy and child birth violates her fundamental right to live as guaranteed under Article 21 of the Constitution of India. And it is the primary duty of the government to ensure that every woman survives pregnancy and child birth, for that, the State of Madhya Pradesh is under obligation to secure their life.

We therefore, recommend following measure to be taken up in the earnest: At Sub-Centres and PHC Level and CHC/District Level-

At Panchayat the 24 hours availability of trained woman as ASHA/Community Health Worker.

Two Auxiliary Nurse Mid-Wives at each Sub-Health Centre.

Three Staff-Nurses at the Primary Health Centre to ensure round the clock service therein.

Strengthen the Outpatient Services through posting/appointment of AYUSH doctors besides regular Medical Officers.

Uninterrupted Electricity supply and the water supply to the Sub-Centres and Public Health Centres.

6. Ensure proper modern sanitation.

7. Ensure that in all Community Health Centres in the State of Madhya Pradesh the availability of 24 hours delivery services including normal and assisted deliveries. It has 30-50 beds. To be equipped with man and machine at par with Indian Public Health Standards, which would include Essential and Emergency Obstetric Care Unit, so that round the clock hospital like services are available.
   Ensure availability of vehicle round the clock under Janani Express Yojna.
   Ensure that every pregnant women and new born is vaccinated with Tetanus, BCG, Polio, DPT etc.
   Form Village Health and Sanction Committee in all villages.

11 - Ensure that at Block Level Regular Camps are held for Jan Sunwai which would include the Sarpanch, Doctors posted within the Block.
   To set up all 87 Rogi Kalyan Samitis.
   Constitute Monitoring Committee at District and Block Level and ensure complete documentation of each and every patient.
   Fix the time bound Schedule of respective Sub-Centres, PHC, CHCs, and the District Hospital.
   These measures though not exhaustive are in addition to the stipulations in PIP 2006-2012.

24. Besides above the State is to ensure strict and timely implementation of the goal of NRHM as per the Implementation Plan 2000 - 2012, so that there can be an effective Control of the MMR.

Respondents are reminded of the fact that the State of Madhya Pradesh having spread over 308.000 sq. kms. with a population of 60.4 million 73% whereof (15.4% of Schedule Caste and 19.9% of Schedule Tribe) living in rural areas and despite of progress on the socio economic front, the State continues to be afflicted with worst indicators in India which include low literacy rate (specially female literacy), high level of morbidity and mortality and approximately 37% of population lying below poverty line as indicated in PIP 2006-2012. It is the duty of the State to see that the MMR which was 498/1lakh live birth should be brought down to the level as indicated by the National Rural Health Mission. To achieve the same, the State will have to strive hard by implementing the Mission Plan in letter and spirit which requires some drastic efforts to be made by the State Government and its functionaries. We expect the State Government to rise to the occasion and will do its best to achieve the goals.

We have not set a separate time period for implementing the recommendation which we have made hereinabove as the period is already set through Programme Implementation Plan 2006-2012.

…

## Shri Rinsing Chewang Kazi v. State of Sikkim & Ors. High Court of Sikkim, PIL 39/2012

## Synopsis

The *Shri Rinsing Chewant Kazi* petition describes the state government's total failure to ensure accessible, adequate, and quality care for women in Sikkim. The High Court has issued notices and directed the state to immediately upgrade supplies of essential drugs in public health facilities.

### Facts

The petitioner documented major issues surrounding adequate health care facilities and transportation in rural areas of Sikkim. In violation of NRHM guarantees, most PHCs do not function 24 hours a day and pregnant women have no choice but to seek care at far-flung facilities. In most cases, pregnant women do make it to the referral facility because of high costs and impossible terrain. Upon arrival at the PHC, women and children are denied quality health care due to poor infrastructure and limited services. The petition narrates the stories of individual women, including the late Chungchungkey Lachenpa, who died after poorly maintained roads delayed her arrival to the PHC. The petition also uncovers the staggering lack of essential and emergency drugs at government facilities.

### Relevant Law

*Constitution:* Article 21 (right to life and right to health), Article 14 (right to gender equality), Article 15 (right to be free from discrimination).
*International Law:* ICESCR (International Covenant on Economic Social and Cultural Rights (ICESCR), Article 12 (right to the highest attainable standard of health), Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Article 12 (elimination of discrimination in health care), Article 14 (protection for rural women), Convention on the Rights of the Child (CRC), Article 24 (right to the highest attainable standard of health for children).
*Statutes & Schemes*: JSY, NRHM, Indian Public Health Standards

## Outcome

HRLN advocate Doma Bhutia submitted the case and the High Court issued notices to the respondents. The Court found that the government schemes had "not been

implemented in the right spirit" and directed the state to report on its public health facilities. Additionally, the Court directed the State to "ensure the availability of life saving drugs in all Hospitals/Health Centres within a period of 2 (two) weeks, if not already available."

## Interim Order

High Court of Sikkim, October 5, 2012

…

Detailed reply within 6 (six) weeks:

From the perusal of the averments made in the Writ Petition, we find that various Govt. sponsored schemes, namely, National Rural Health Mission (NRHM), Janani Suraksha Yojana (JSY) and other schemes have not been implemented in right spirit. There are also averments regarding non-availability of life saving drugs in most of the Government Hospitals/Health Centres both at District and Sub-Divisional levels. State respondents will furnish details of the facilities available at District and Sub-Divisional level Hospitals and Primary Health Centres including dispensaries with details of the number of such Centres. The availability of life saving drugs with its name/brand and quantity with the expiry dates will also be disclosed in the affidavit so filed.

In the meantime, we further direct that the State will ensure availability of life saving drugs in all the Hospitals/Health Centres within a period of two (2) weeks, if not already available.

# Snehalata "Salenta" Singh v. State of Uttar Pradesh, High Court of Allahabad W.P. 14588/2009

## Synopsis

In *Salenta*, a woman suffered a vaginal fistula as a result of negligent treatment in a public facility during her labor. In the 10 months after Salenta's delivery, she was either repeatedly refused care or, when given care, it was entirely inadequate. She filed suit, claiming that the medical negligence violated her rights to health and a dignified life. The Government has only recently filed its response, and the next hearing is pending.

### Facts

Having previously given birth to five children naturally and at home, Salenta 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. Additionally, PHC officials forced her husband to purchase her medication and extorted an illegal bribe from Salenta 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, Salenta visited eight different health centers before her condition was correctly treated through surgery. Salenta 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.

Salenta 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.

Salenta is 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

## Outcome

The government filed its reply, HRLN advocates have responded and matter is listed for hearing.

# Maternity Leave and Employment Discrimination

## Municipal Corporation of Delhi v. Female Workers (Muster Roll), Supreme Court AIR 2000 SC 1274

### Synopsis

Unlike contract employees, female muster roll, or daily wage, workers employed by the Municipal Corporation of Delhi (MCD) were denied maternity leave. Through the Delhi Municipal Workers Union, they filed suit requesting a grant of maternity leave and other benefits, in accordance with the Maternity Benefit Act (the Act). Based on the Constitution of India, as well as international law, the Court ordered that the MCD confer maternity benefits to all workers, regardless of whether they were employed under formal contracts or not.

### Facts

Many of the female muster roll workers were employed for as many days as contract workers, but merely lacked the formality of a contract. As such, they were denied maternity leave and other benefits under the Act. Without leave, these impoverished women continued to perform difficult and dangerous manual labor throughout their pregnancies and high risk post-natal period. Not only did this pose a threat to their health and that of their infants, but the denial of maternity benefits also breached their labor rights under Indian and international law.

### Relevant Law

*Constitution*: Articles 14 (right to equal protection), 15 (right to be free from discrimination), & 15(3) (encouraging special provisions for the advancement of women and children)
*Cases*: *Hindustan Antibiotics Ltd. v. Workmen*, 1967 AIR 948 (holding that Article 14 requires the government to treat all labour sectors alike)
*Statutes & Schemes*: Maternity Benefit Act, 1961
*International Law*: CEDAW Article 11 (States Parties should protect women's labour rights, including by providing maternity leave)

## Outcome

Though the MCD argued that the Act only applied to regularized workers and not temporary, daily wage workers, the Court rejected this contention. Nothing in the Act provides that only contract workers are eligible for maternity leave. Most importantly, the Court highlighted that the Constitution of India prohibits discrimination and, furthermore, directs the government to improve the people's social and economic standards and to ensure adequate labour conditions and maternal health for all. In addition, the Court referred to international law binding India to observe these standards of labour rights and maternity leave.

## Judgment

1. Female workers (muster roll), engaged by the Municipal Corporation of Delhi (for short, 'the Corporation'), raised a demand for grant of maternity leave which was made available only to regular female workers but was denied to them on the ground that their services were not regularised and, therefore, they were not entitled to any maternity leave. Their case was espoused by the Delhi Municipal Workers Union (for short, 'the Union') and, consequently, the following question was referred by the Secretary (Labour), Delhi Administration to the Industrial Tribunal for adjudication:

   > "Whether the female workers working on Muster Roll should be given any maternity benefit? If so, what directions are necessary in this regard?"

2. The Union filed a statement of claim in which it was stated that Municipal Corporation of Delhi employs a large number of persons including female workers on muster roll and they are made to work in that capacity for years together though they are recruited against the work of perennial nature. It was further stated that the nature of duties and responsibilities performed and undertaken by the muster roll employees are the same as those of the regular employees. …but the Corporation does not grant any maternity benefit to female workers who are required to work even during the period of mature pregnancy or soon after the delivery of child. It was pleaded that the female workers required the same maternity benefits as were enjoyed by regular female workers under the Maternity Benefit Act, 1961. The denial of these benefits exhibits a negative attitude of the Corporation in respect of a humane problem.

3. The Corporation in their written statement, filed before the Industrial Tribunal, pleaded that the provisions under the Maternity Benefit Act, 1961 or Central Civil Services (Leave) Rules were not applicable to the female workers, engaged on muster

roll, as they were all engaged any on daily wages. It was also contended that they were not entitled to any benefit under the Employees' State Insurance Act, 1948. It was for these reasons that the Corporation contended that the demand of the female workers (muster roll) for grant of maternity leave as liable to be rejected.

4. The Tribunal, by its Award dated 2nd of April, 1996, allowed the claim of the female workers (muster roll) and directed the Corporation to extend the benefits under the Maternity Benefit Act, 1961 to muster roll female workers who were in the continuous service of the Corporation for three years or more. …
…

6. Not long ago, the place of a woman in rural areas has been traditionally her home; but the poor illiterate women forced by sheer poverty now come out to seek various jobs so as to overcome the economic hardship. They also lake up jobs which involve hard physical labour. … Since they are engaged on daily wages, they, in order to earn their daily bread, work even in advance stage of pregnancy and also soon after delivery, unmindful of -detriment to their health or to the health of the new-born. It is in this background that we have to look to our Constitution which, in its Preamble, promises social and economic justice. We may first look at the Fundamental Rights contained in Chapter III of the Constitution. Article 14 provides that the State shall not deny to any person equality before law or the equal protection of the laws within the territory of India. Dealing with this Article vis-a-vis the Labour Laws, this Court in Hindustan Antibiotics Ltd. v. Workmen , has held that labour to whichever sector … will be treated on equal basis. Article 15 provides that the State shall not discriminate against any citizen on grounds only of religion, race, caste, sex, place of birth or any of them. Clause (3) of this Article provides as under:

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

…

8. From Part III, we may shift to Part IV of the Constitution containing Directive Principles of State Policy. Article 38 provides that the State shall strive to promote the welfare of the people by securing and protecting, as effectively as it may, a social order in which justice, social, economic and political shall inform all the institutions of the national life. Sub-clause (2) of this Article mandates that the State shall strive to minimise the inequalities in income and endeavour to eliminate inequalities in status, facilities and opportunities.

**Article 39 provides, inter alia, as under:**

"39. Certain principles of policy to be followed by the State - The State shall, in particular, direct its policy towards securing -

(a) that the citizens, men and women equally, have the right to an adequate means of livelihood;

(b) & (c)...

(d) that there is equal pay for equal work for both men and women:

(e) that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength;

(f)..."

**Articles 42 and 43 provides as under :**

"42, Provision for just and humane conditions of work and maternity relief - The State shall make provision for securing just and humane conditions of work and for maternity relief.

43. Living wage, etc., for workers - The State shall endeavour to secure, by suitable legislation or economic organisation or In any other way, to all workers, agricultural, industrial or otherwise, work, a living wage, conditions of work ensuring a decent standard of life and full enjoyment of leisure and social and cultural opportunities and, in particular, the State shall endeavour to promote cottage industries on an individual or co-operative basis in rural areas."

…

10. Since Article 42 specifically speaks of "just and humane conditions of work" and "maternity relief, the validity of an executive or administrative action in denying maternity benefit has to be examined on the anvil of Article 42 which, though not enforceable at law, is nevertheless available for determining the legal efficacy of the action complained of.

…

24. The provisions of the Act which have been set out above would indicate that they are wholly in consonance with the Directive Principles of State Policy, as set out in Article 39 and in other Articles, specially Article 42. A woman employee, at the

time of advanced pregnancy cannot be compelled to undertake hard labour as it would be detrimental to her health and also to the health of the foetus. It is for this reason that It is provided in the Act that she would be entitled to maternity leave for certain periods prior to and after delivery. We have scanned the different provisions of the Act, but we do not find anything contained in the Act which entitles only regular women employees to the benefit of maternity leave and not to those who are engaged on casual basis of on muster roll on daily wage basis.

…

30. A just social order can be achieved only when inequalities are obliterated and everyone is provided what, is legally due. When who constitute almost half of the segment of our society have to be honoured and treated with dignity at places where they work to earn their livelihood. Whatever be the nature of their duties, their avocation and the place where they work; they must be provided all the facilities to which they are entitled. To become a mother is the most natural phenomena in the life of a woman. Whatever is needed to facilitate the birth of child to a woman who is in service, the employer has to be considerate and sympathetic towards her and must realise the physical difficulties which a working woman would face in performing her duties at the work place while carrying a baby in the womb or while rearing up the child after birth. The Maternity Benefit Act, 1961 aims to provide all these facilities to a working woman in a dignified manner so that she may overcome the state of motherhood honourably, peaceably, undeterred by the fear, of being victimised for forced absence during the pre or post-natal period.

31. Next it was contended that therefore the benefits contemplated by the Maternity Benefit Act, 1961 can be extended only to workwomen in an 'industry' and not to the muster roll women employees of the Municipal Corporation. This is too stale an argument to be heard. Learned Counsel also forgets that Municipal Corporation was treated to be an 'industry' and, therefore, a reference was made to the Industrial Tribunal, which answered the reference against the Corporation, and it is this matter which is being agitated before us.

    …

33. Taking into consideration the enunciation of law as settled by this Court as also the High Courts in various decisions referred to above, the activity of the Delhi Municipal Corporation by which construction work is undertaken or roads are laid or repaired or trenches are dug would fall within the definition of "industry". The workmen or, for that matter, those employed on muster roll for carrying on these activities would, therefore, be "workmen" and the dispute between them and the Corporation would have to be tack led as an industrial dispute in the light of various

statutory provisions of the Industrial Law, one of which is the Maternity Benefit Act, 1961. …

34. Delhi is the capital of India. No other City or Corporation would be more conscious than the City of Delhi that India is a signatory to various International covenants and treaties. The Universal Declaration of Human Rights, adopted by the United Nations on 10th of December, 1948 set in motion the universal thinking that human rights are supreme and ought to be preserved at all costs. This was followed by a series of Conventions. On 18th of December, 1979, the United Nations adopted the "Convention on the Elimination of all forms of discrimination against women". Article 11 of this Convention provides as under:

**"Article 11**

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;

   …

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 provision 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 to women during pregnancy in types of work proved to be harmful to them.

   …

35. These principles which are contained in Article 11, reproduced above, have to be read into the contract of service between Municipal Corporation of Delhi and the women employees (muster roll); and so read these employees immediately become entitled to all the benefits conceived under the Maternity Benefit Act, 1961. … In the meantime, the benefits under the Act shall be provided to the women (muster roll) employees of the Corporation who have been working with them on daily wages.

# S. Amudha v. Chairman, Neyveli Lignite Corporation, Madras High Court (1991) IILLJ 234 Mad

## Synopsis

In *S. Amudha*, the Madras High Court struck down a regulation defining women more than four months pregnant as "temporarily unfit" for employment. The Court held that the regulation violated Articles 14 and 21 of the Constitution of India.

### Facts

The victim in this case was the only contract laborer out of 40 to be denied permanent appointment as a Junior Chemist. When she asked for the reason, her employers told her that because she was 4 months pregnant an appointment order would be given 3 months after she gave birth. Her employers also said that she would not earn wages during the interim period. The victim argued that the state violated her rights under Articles 14 and 21 of the Constitution of India and furthermore, that she was entitled to benefits under the Maternity Benefit Act, 1961.

### Relevant Law

*Constitution*: Articles 14 (right to equal protection) & 21 (right to a dignified life)
*Cases*: *Griswold v. Connecticut* 381 US 479 (1965) (A husband and wife's marital relations falls within the private realm of family that that is protected from unnecessary regulations by the State); *Air India v. Nergesh Meerza and Ors.* 1981 AIR 1829 (The Court struck down a rule dismissing airline hostesses at their first pregnancy; if the airline felt hostesses were medically unable to fly while pregnant, the airline would be free to provide maternity leave for a 14 – 16 month period)
*Statutes & Schemes*: Maternity Benefit Act, 1961

## Outcome

The Court struck down the employer's regulation that deemed a woman four or more months pregnant temporarily unfit for employment, holding that such a regulation violated the right to life protected by Article 21 of the Constitution. The Court elaborated saying, "'Life' in this Article cannot be considered to be a mechanical one. It is attendant with all that is required to make the life blossom and all enjoyment within the permissible limits of law." Indeed, to deny maternity benefits in these circumstances would curtail the life and personal freedom of the appellant. Furthermore, the fact that

the Appellant would suffer the loss of wages for the period during which she was not employed was a deprivation of livelihood—a fundamental right enshrined under Article 21 of the Constitution.

The Court also held that the regulation violated Article 14 of the Constitution in that it was too vague and could be applied arbitrarily.

## Judgment

1. The short facts leading to the writ appeal are as follows :

   The appellant … is the mother of two daughters and she was in the family way of four months at the time of filing the writ petition.

2. The appellant was entertained as a Junior Chemist on and from 1st January, 1986 on contract basis, and Babu Engineering Corporation was given the contract pertaining to chemical test of soil, clay, water, oil and metal within the percincts of the Neyveli Lignite Corporation Ltd., Neyveli. Though the work involving chemical test by the Chemist is necessarily throughout the year, the management of the Neyveli Lignite Corporation Ltd. extracted the work from the Chemist numbering about forty through Babu Engineering Corporation who paid at the rate of Rs. 10 per day to each Chemist and in that capacity, the appellant worked for about three years.

3. The appellant filed W.P. 3920 of 1988 against the respondent to regularise her services and to abolish the contract labour system and the said writ petition has been admitted by this Court.

   …

6. The appellant was asked to fill up a pro forma in order to appoint her as Junior Chemist, In column No. 7, the appellant had categorically stated that she was having CARD (Centre of Applied Research and Development) for entry into the Centre for Applied Research and Development wing of the respondent. She had in fact worked as Junior Chemist from 1st January, 1986 to 28th December, 1988, and even today she is working as a casual contract labourer on a daily wage of Rs. 15. Her duty involved chemical test of articles and her name has also been registered in the local Employment Exchange.

7. The appellant was called for an interview for selection as Junior Chemist on 11th February, 1989. However, the interview did not take place and it was postponed. .... By a communication dated 14th April, 1989, she was asked to appear before the Medical Officer, on 19th May, 1989. On that date, about forty persons were

medically examined. ... Though appointment orders were issued to all the thirty-nine persons who were working along with the appellant under the contract labour system, the appellant alone was singled out. When the appellant approached the respondent she was informed that she was in the family way carrying a child of sixteen weeks. Thereupon, the appellant and her husband met Mr. Mani Iyer, Mr. Krishnan and others and the appellant was informed that the appointment order will be issued only after the appellant giving birth to the child and that too after a period of three months from the date of birth of the child.

8. ... It is under these circumstances, the writ petition was filed alleging that her non-selection only on the ground that she was in the family way by sixteen weeks is violative of Arts. 14, 15 and 21 of the Constitution of India. At no point of time, the appellant was let known about this temporary unfitness. In so far as there is no stipulation when the application was made that a pregnant woman cannot be considered, that ground cannot prevail. The appellant would also be entitled to the benefits under the Maternity Benefit Act, 1961. When there is no physical hindrance while the appellant was working under the contract labour system, pregnancy cannot be a ground even to temporarily disqualify her.

…

11. Mr. Prakash, learned Counsel for the appellant, would urge that such a Regulation based on pregnancy is violative of Art. 14 of the Constitution of India. Further, in so far as the Regulation does not classify the category of services, it could arbitrarily be applied …. Looked at from the point of view of Art. 21 of the Constitution, the appellant has a right to life. Such a life does not mean a mechanical one, bases on personal freedom. In the case of a woman, certainly she has every freedom to have a child and the Constitutional right cannot be taken away by a regulation of this character. The right to beget children is a very valuable right. … Learned Counsel submitted that if the working of the appellant under a contract labour is not hazardous, the same could be so if she is obliged to work under the Corporation as well. Therefore, this cannot be a valid ground at all. Lastly it is submitted that the Maternity Benefit Act 1961 itself has not though of medical unfitness for a pregnancy of 16 weeks old and the Regulation in question cannot exceed a parliamentary legislation and lay down a prescription which cannot be supported even from the medical point of view.

12. Mr. R. Krishnaswami, learned Counsel for the respondent, after referring to the Regulations states that this is one conceived in the interest of the employees themselves. Further, such a regulation requiring medical examination at the time of the first appointment is not peculiar. Such regulations are there in police

organisation as well. Where the work is of a hazardous nature, it becomes necessary for the employer to lay down such a condition like this. In any event, as the counter affidavit states, this is only a temporary unfitness. After the delivery of the child, the appellant is entitled to join and her seniority will not any way be interface with. …

13. Having regard to the above submissions made on both sides, the only question that arises for our consideration is, whether the regulation in question in relation to medical examination of a female candidate is violative of any of the provisions of the Constitution and is therefore liable to be struck down. We will now straightway, extract the said regulation as under :

> "R. 21 : The duration of pregnancy, if any, should be recorded in case of female candidates. The woman in advanced stages of pregnancy should be deemed to be temporarily unfit. For this purpose pregnancy of four months and over may taken as advanced stage of pregnancy."

14. It is admitted that the appellant was interviewed and she was also selected. However, her selection was withheld on the only ground that she was in the family ways by 16 weeks. The counter affidavit filed in the writ appeal in paragraphs 6 and 7 states as follows:

> "she was in the advanced stage of pregnancy as per rules in force of the respondent company and she was temporarily disqualified from joining duty immediately. She was also advised to report before the Medical Committee after six weeks of confinement. It is also submitted that the appellant is not likely to lose any benefit such as seniority, etc., and as the seniority would be reckoned based upon her position in the selection panel as recommended by the Committee. … The only loss that the appellant has to suffer is the loss of wages for the period during which she was not employed and this is inevitable because of the rules in force. She is not actually working during that period.
>
> It is further submitted that the area of work where the appellant has to work as Junior Chemist will be either CARD (Centre for Applied Research) or Fertilizer, B & C factory. In all these areas, a Junior Chemist has to handle chemicals and has to be exposed to the different chemicals and gases which are likely to endanger the health of a pregnant lady. While a normal person can withstand these hazards, a lady carrying a baby is quite likely to be affected by exposure to these elements and which may endanger the life of the child or result in miscarriage. This statement is based upon the medical opinion."

15. We may at once state that we are not in a position to accept what is stated in paragraph 7 of the counter because this was not the stand taken by the respondent

before the learned single Judge and this is an ingenious attempt by the respondent to defeat the claim of the appellant. In this connection it should be remembered that the appellant was working as a contract labourer in the very post for which she was selected and the post has not been considered as the one involving health hazard. If the ground of 'health hazard' has not been pressed into service when the appellant was working under the contract labour, how could the same be projected at the time of her permanent appointment? We find great difficulty in accepting this argument, and therefore, the rejection of the claim of the appellant for the appointment on the ground of 'health hazard' is not sustainable. Regarding the argument that such 'temporary unfitness' is not anything peculiar to the respondent Corporation, but is also there in similar public sector Corporations like Bharat Heavy Electricals Ltd, and National Thermal Power Corporation, we would refer to a passage occurring at page 166 of Swamy's Complete Manual on Establishment and Administration. The passage reads as under:

"Employment of women candidates in state of pregnancy -

(a) For appointment against posts carrying hazardous nature of duties - Where a pregnant woman candidate is to be appointed against a post carrying hazardous nature of duties, e.g., in Police Organisations, etc., and she has to complete a period of training as a condition of service and who as a result of tests is found to be pregnant of twelve weeks standing or over shall be declared temporarily unfit and her appointment held in abeyance until the confinement is over.
She should be re-examined for a fitness certificate six weeks after the date of confinement, subject to the production of medical certificate of fitness from a registered medical practitioner. The vacancy against which the woman candidate was selected should be 'kept reserved for her. If she is found fit, she may be appointed to the post kept reserved for her and allowed the benefit of seniority in accordance with para 4 of Annexure to MHA OM No. 9/11/55-R.S, dated the 22nd December, 1959.

(b) For appointments against posts which do not prescribe any elaborate training - It shall no longer be necessary to declare a woman candidate 'compulsorily unfit' if she is found to be pregnant during medical examination before appointment against posts which do not prescribe any elaborate training, i.e., she can be appointed straightway on the job."

16. The question now is, whether there could be a prescription of this type in the light of the fundamental rights conferred under Art. 21 of the Constitution of India. That Article reads as follows :

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

'Life' in this Article cannot be considered to be a mechanical one. It is attendant with all that is required to make the life blossom and all enjoyment within the permissible limits of law. Here is the case of a married woman. If she chooses to have a child, can the State or an authority like the respondent corporation impose itself and curtail this life or the personal freedom of the appellant? In this connection, we find the various American decisions relied on by the learned Counsel for the appellant throw a good deal of light.

17. In Griswold v. Connecticut (supra) it is observed as follows:

"The present case, then concerns a relationship laying within the zone of privacy created by several fundamental constitutional guarantees. And it concerns a law which, in forbidding the use of contraceptives rather than regulating their manufacture or sale, seeks to achieve its goals by means having a maximum destructive impact upon that relationship. Such a law cannot in light of the familiar principle, so often applied by this Court, that a Governmental purpose to control or prevent activities constitutionally subject to State regulation may not be achieved by means which sweep unnecessarily, broadly and thereby invade the area of protected freedoms. Would we allow the police to search the sacred precincts of marital bedrooms for tell tale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship.

We deal with a right of privacy older than the Bill of Rights-older than our political parties, older than our schools system. … Yet, it is an association for as noble a purpose as any involved in our prior decisions."

In the same judgment, the Supreme Court of the United States observed as follows:

"The home derives its pre-eminence as the seat of family life. And the integrity of that life is something so fundamental that it principles of more than one explicitly granted Constitutional rights. Of this whole 'Private realm of family life' it is difficult to imagine what is more private or more intimate than a husband and wife's marital relations."

Therefore, if the regulation in question tends to affect the 'Private realm of family life', we consider that the ratio of this judgment will squarely apply.

…

23. In Air India v. Nergesh Meerza (1981-II-LLJ-314 at 335) the Supreme Court of India observed as follows:

"Coming now to the second limb of the provisions according to which the services of AHs (Air Hostesses) would stand terminated on first pregnancy, we

find … that this is a most unreasonable and arbitrary provision which shocks the conscience of the Court. The Regulation does not prohibit marriage after four years and if an A.H. after having fulfilled the first condition becomes pregnant, there is not reason why pregnancy should stand in the way of her continuing in service. The Corporation represented to us that the pregnancy leads to a number of complications and to medical disabilities which may stand in the efficient discharge of the duties by the A. Hs. It was said that even in the early stage of pregnancy some ladies are prone to get sick due to air pressure, nausea in long flight and such other technical factors. This, however, appears to be purely an artificial argument because once a married woman is allowed to continue in service then under the provisions of the Maternity Benefit Act, 1961 and the Maharashtra Maternity Rules, 1965 (these apply to both the Corporations as their Head Offices are at Bombay) she is entitled to certain benefits including maternity leave. In case, however, the Corporations feel that pregnancy from the very beginning may come in the way of discharge of the duties of some of the A. Hs. they could be given maternity leave for a period of 14 to 16 months and in the meanwhile there could be no difficulty in the Management making arrangements on a temporary or ad hoc basis by employing additional A. Hs. We are also unable to understand the argument of the Corporation that a woman after bearing children becomes weak in physique of in her constitution. There is neither any legal or medical authority for this bald proposition."

The above observations came to be made by the Supreme Court while dealing with the right of an air hostess to get married.

…

26. An attempt was made to call the restriction as 'temporary unfitness' and that the she could join duty after the birth of the child. ... This stand, to our mind, appears to be a ruse to get over a difficult situation. The maintaining of the original seniority and her obtaining the proper place is poor consolation indeed. As the respondent himself has categorically stated, she will have to suffer the loss of wages for the period during which she was not in employment. Who is to compensate her for the loss of money? Does it not mean deprivation of livelihood which is a fundamental right contemplated under Art. 21 of the Constitution? In these days of acute unemployment, to deprive a woman of her right to earn in spite of her selection is something which we cannot appreciate at all. To say that she is temporarily unfit is something which stand scrutiny from the medical point of view. It is not an uncommon sight in India to see a woman in advanced stages of pregnancy working

in agricultural fields, on roads or even in mines where there is every risk. Yet, they dare work, compelled by poverty and by the dire necessity of life.

…

28. The Regulation since so far as it does not classify the category of services, and it is made applicable to all services whether a stenographer or an assistant doing desk work, undoubtedly suffers from the vice of arbitrariness. Therefore, it is violative of Art. 14 of the Constitution as well.

29. ... Let it be remembered that where children are, there is the golden age. One begets children not merely to keep up the race, but to enlarge our hearts and make us unselfish and full of kindly sympathies and affections, to give our souls higher aims, to call out all our faculties to extend enterprise and exertion and to bring round our fireside bright faces, happy smiles, and loving, tender hearts. If this is sought to be deprived by the Regulation in question the same to be violative of the fundamental rights guaranteed under Art. 21, as well as Art. 14 of the Constitution?

…

# Sex Selection

## Centre for Enquiry into Health and Allied Themes (CEHAT) v. Union of India, Supreme Court AIR 2003 SC 3309

### Synopsis

In response to the Central and State Governments' lack of implementation of the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act ('the PNDT Act'), the Supreme Court condemned the use of modern technology for the purpose of sex determination leading to sex selective abortion. The Court directed the Central and State Governments to take steps necessary to implement the PNDT Act to prevent the misuse of such technology.

#### Facts

This PIL reveals that despite legislation prohibiting sex selection, the Central Government and State Governments have failed to take steps to implement the provisions of the PNDT Act in violation of multiple court orders. Data from the 2011 Census shows that sex selective abortion and pre-natal sex determination are still common. This has lead to widening sex ratios, especially in economically advanced states.

#### Relevant Law

*Statutes & Schemes*: The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994

### Outcome

The Court reiterated language from several previous orders directing the Centre and State Governments to take appropriate action to implement various provisions of the PNDT Act. Specifically, in May 2001, the Court directed the Centre Government to create public awareness of pre-natal determination of sex and sex selective abortion through appropriate press releases, programmes in electronic media. The Court also ordered the Centre Government to implement other provisions of the PNDT Act and Rules framed in 1996. Furthermore, the Court directed the Central Supervisory Board (CSB):

- To meet, review, and monitor the implementation of the PNDT Act,
- To issue directions to all States,

- To collect reports from appropriate authorities on implementation,
- To establish an appropriate code of conduct,
- To require medical professional bodies/associations to create awareness against the practice of pre-natal sex determination and sex selective abortion,
- And to ensure implementation of the Act.

The Court directed State Governments
- To appoint and publish a list of Appropriate Authorities and Advisory Committees,
- To create public awareness against the practice of pre-natal sex determination and sex selective abortion, and
- To furnish quarterly reports to CBS.

The Court directed Appropriate Authorities to take prompt action against those in violation of the PNDT Act.

In September 2001, the Court acknowledged inadequate implementation of the PNDT Act and noted that no meaningful action was being taken against unregistered Genetic Counselling Centres, Genetic Laboratories or Genetic Clinics. The Court directed government authorities to carry out necessary surveys of Clinics and take appropriate action in cases of non-registration or non-compliance with the Act and its Rules. Furthermore, the Court directed State Governments to submit reports to CSB as previously directed.

In November 2001, the Court ordered the Centre Government to establish a National Inspection and Monitoring Committee for the implementation of the Act. Additional orders were issued in December 2001 and March 2003 on implementation of specific provisions of the Act. In September 2003, the Court directed that the above mentioned orders be complied with and directed the Centre and State Governments to engage in a public awareness campaign to eliminate discrimination between male and female children, make information available to public at large, and maintain records of Advisory Committee meetings.

## Judgment

1. It is an admitted fact that in Indian Society, discrimination against girl child still prevails, may be because of prevailing uncontrolled dowry system despite the Dowry Prohibition Act, as there is no change in the mind-set or also because of insufficient education and/or tradition of women being confined to household activities. Sex selection/sex determination further adds to this adversity. It is also known that number of persons condemn discrimination against women in all its forms, and

agree to pursue, by appropriate means, a policy of eliminating discrimination against women, still however, we are not in a position to change mental set-up which favours a male child against a female. Advance technology is increasingly used for removal of foetus (may or may not be seen as commission of murder) but it certainly affects the sex ratio. The misuse of modern science and technology by preventing the birth of girl child by sex determination before birth and thereafter abortion is evident from the 2001 Census figures which reveal greater decline in sex ratio in the 0-6 age group in States like Haryana, Punjab, Maharashtra and Gujarat, which are economically better off.

2. Despite this, it is unfortunate that law which aims at preventing such practice is not implemented and, therefore, Non-Governmental Organisations are required to approach this Court for implementation of the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 renamed after amendment as "The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act" (hereinafter referred to as 'the PNDT Act') which is the normal function of the Executive.

3. In this petition, it was inter alia prayed that as the Pre-natal Diagnostic Techniques contravene the provisions of the PNDT Act, the Central Government and the State Governments be directed to implement the provisions of the PNDT Act (a) by appointing appropriate authorities at State and District levels and the Advisory Committees; (b) the Central Government be directed to ensure that Central Supervisory Board meets every 6 months as provided under the PNDT Act; and (c) for banning of all advertisements of pre-natal sex selection including all other sex determination techniques which can be abused to selectively produce only boys either before or during pregnancy.

…

5. A] On 4th May 2001, following order was passed:
"It is unfortunate that … the practice of female infanticide still prevails despite the fact that gentle touch of a daughter and her voice has soothing effect on the parents. One of the reasons may be the marriage problems faced by the parents coupled with the dowry demand by the so-called educated and/or rich persons who are well placed in the society. The traditional system of female infanticide whereby female baby was done away with after birth by poisoning or letting her choke on husk continues in a different form by taking advantage of advance medical techniques. ... Knowing full well that it is immoral and unethical as well as it may amount to an offence, foetus of a girl child is aborted by qualified and unqualified doctors or compounders. This has affected overall sex ratio in various States where female infanticide is prevailing without any hindrance.

For controlling the situation, the Parliament in its wisdom enacted the Pre-natal Diagonstic Techniques (Regulation and Prevention of Misuse) Act, 1994 (hereinafter referred to as "the PNDT Act"). The Preamble, inter alia, provides that the object of the Act is to prevent the misuse of such techniques for the purpose of pre-natal sex determination leading to female feoticide…

It is apparent that to a large extent, the PNDT Act is not implemented by the Central Government or by the State Governments. Hence, the petitioners are required to approach this Court under Article 32 of the Constitution of India. One of the petitioners is the Centre for Enquiry Into Health and Allied Themes (CEHAT) which is a research center of Anusandhan Trust based in Pune and Mumbai. Second petitioner is Mahila Sarvangeen Utkarsh Mandal (MASUM) based in Pune and Maharashtra and the third petitioner is Dr. Sabu M. Georges who is having experience and technical knowledge in the field. .... It took nearly one year for the various States to file their affidavits in reply/written submissions. Prima facie it appears that despite the PNDT Act being enacted by the Parliament five years back, neither the State Governments nor the Central Government has taken appropriate actions for its implementation. Hence, after considering the respective submissions made at the time of hearing of this matter, as suggested by the learned Attorney General for India, Mr. Soli J. Sorabjee following directions are issued on the basis of various provisions for the proper implementation of the PNDT Act: -

## I. Directions to the Central Government

1. The Central Government is directed to create public awareness against the practice of pre- natal determination of sex and female foeticide through appropriate releases/ programmes in the electronic media. This shall also be done by Central Supervisory Board ("CSB" for short) as provided under Section 16(iii) of the PNDT Act.

2. The Central Government is directed to implement with all vigor and zeal the PNDT Act and the Rules framed in 1996. Rule 15 provides that the intervening period between two meetings of the Advisory Committees constituted under sub-section (5) of Section 17 of the PNDT Act to advise the appropriate authority shall not exceed 60 days. It would be seen that this Rule is strictly adhered to.

## II. Directions to the Central Supervisory Board (CSB)

1. Meetings of the CSB will be held at least once in six months. [Re. Proviso to Section 9(1)] The constitution of the CSB is provided under Section 7. It empowers the Central Government to appoint ten members under Section 7(2)(e) which includes

eminent medical practitioners including eminent social scientists and representatives of women welfare organizations. We hope that this power will be exercised so as to include those persons who can genuinely spare some time for implementation of the Act.

2. The CSB shall review and monitor the implementation of the Act. [Re. Section 16(ii)].

3. The CSB shall issue directions to all State/UT. Appropriate Authorities to furnish quarterly returns to the CSB giving a report on the implementation and working of the Act. These returns should inter alia contain specific information about: -
   (i) Survey of bodies specified in section 3 of the Act.
   (ii) Registration of bodies specified in section 3 of the Act.
   (iii) Action taken against non-registered bodies operating in violation of section 3 of the Act, inclusive of search and seizure of records.
   (iv) Complaints received by the Appropriate Authorities under the Act and action taken pursuant thereto.
   (v) Number and nature of awareness campaigns conducted and results flowing therefrom.

4. The CSB shall examine the necessity to amend the Act keeping in mind emerging technologies and difficulties encountered in implementation of the Act and to make recommendations to the Central Government. [Re. Section 16]

5. The CSB shall lay down a code of conduct under section 16(iv) of the Act to be observed by persons working in bodies specified therein and to ensure its publication so that public at large can know about it.

6. The CSB will require medical professional bodies/associations to create awareness against the practice of pre-natal determination of sex and female foeticide and to ensure implementation of the Act.

## III. Directions to State Governments/UT Administrations

1. All State Governments/UT Administrations are directed to appoint by notification, fully empowered Appropriate Authorities at district and sub-district levels and also Advisory Committees to aid and advise the Appropriate Authority in discharge of its functions [Re. Section 17(5)]. For the Advisory Committee also, it is hoped that members of the said Committee as provided under section 17(6)(d) should be such persons who can devote some time for the work assigned to them.

2. All State Governments/UT Administrations are directed to publish a list of the Appropriate Authorities in the print and electronic media in its respective State/UT.

3. All State Governments/UT Administrations are directed to create public awareness against the practice of pre-natal determination of sex and female foeticide through advertisement in the print and electronic media by hoarding and other appropriate means.

4. All State Governments/UT Administrations are directed to ensure that all State/UT appropriate Authorities furnish quarterly returns to the CSB giving a report on the implementation and working of the Act. These returns should inter alia contain specific information about: -
   (i) Survey of bodies specified in section 3 of the Act.
   (ii) Registration of bodies specified in section 3 of the Act.
   (iii) Action taken against non-registered bodies operating in violation of section 3 of the Act, inclusive of search and seizure of records.
   (iv) Complaints received by the Appropriate Authorities under the Act and action taken pursuant thereto.
   (v) Number and nature of awareness campaigns conducted and results flowing therefrom.

## IV. Directions to Appropriate Authorities

1. Appropriate Authorities are directed to take prompt action against any person or body who issues or causes to be issued any advertisement in violation of section 22 of the Act.

2. Appropriate Authorities are directed to take prompt action against all bodies specified in section 3 of the Act as also against persons who are operating without a valid certificate of registration under the Act.

3. All State/UT Appropriate Authorities are directed to furnish quarterly returns to the CSB giving a report on the implementation and working of the Act. These returns should inter alia contain specific information about: -

   (i) Survey of bodies specified in section 3 of the Act.

   (ii) Registration of bodies specified in section 3 of the Act including bodies using ultrasound machines.

(iii) Action taken against non-registered bodies operating in violation of section 3 of the Act, inclusive of search and seizure of records.

(iv) Complaints received by the Appropriate Authorities under the Act and action taken pursuant thereto.

(v) Number and nature of awareness campaigns conducted and results flowing therefrom.

The CSB and the State Governments/Union Territories are directed to report to this Court on or before 30th July 2001. ..."

6. B] Inspite of the above order, certain States/UTs did not file their affidavits. Matter was adjourned from time to time and on 19th September, 2001, following order was passed:

"… From the said affidavits, it appears that the directions issued by this Court are not complied with.

1. At the outset, we may state that there is total slackness by the Administration in implementing the Act. Some learned counsel pointed out that even though the Genetic Counselling Centre, Genetic Laboratories or Genetic Clinics are not registered, no action is taken as provided under Section 23 of the Act, but only a warning is issued. In our view, those Centres which are not registered are required to be prosecuted by the Authorities under the provisions of the Act and there is no question of issue of warning and to permit them to continue their illegal activities. It is to be stated that the Appropriate Authorities or any officer of the Central or the State Government authorised in this behalf is required to file complaint under Section 28 of the Act for prosecuting the offenders.

Further wherever at District Level, appropriate authorities are appointed, they must carry out the necessary survey of Clinics and take appropriate action in case of non-registration or non-compliance of the statutory provisions including the Rules. Appropriate authorities are not only empowered to take criminal action, but to search and seize documents, records, objects etc. of unregistered bodies under Section 30 of the Act.

2. It has been pointed out that the States/Union Territories have not submitted quarterly returns to the Central Supervisory Board on implementation of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994

(hereinafter referred to as "the Act"). Hence it is directed that the quarterly returns to Central Supervisory Board should be submitted giving the following information:-

(a) Survey of Centres, Laboratories/Clinics,

(b) Registration of these bodies,

(c) Action taken against unregistered bodies,

(d) Search and Seizure,

(e) Number of awareness campaigns, and

(f) Results of campaigns"

7. C] On 7th November, 2001, learned counsel for the Union of India stated that the Central Government has decided to take concrete steps for the implementation of the Act and suggested to set up National Inspection and Monitoring Committee for the implementation of the Act. It was ordered accordingly.

8. D] On 11th December, 2001, it was pointed out that certain State Governments have not disclosed the names of the members of the Advisory Committee. Consequently, the State Governments were directed to publish the names of advisory committee in various districts so that if there is any complaint, any citizen can approach them. The Court further observed thus:

> "For implementation of the Act and the rules, it appears that it would be desirable if the Central Government frames appropriate rules with regard to sale of ultrasound machines to various clinics and issue directions not to sell machines to unregistered clinics. ..."

9. E] On March 31, 2003, it was pointed out that in conformity with the various directions issued by this Court, the Act has been amended and titled as "The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act". It was submitted that people are not aware of the new amendment and, therefore, following reliefs were sought:

a) direct the Union of India, State Governments / UTs and the authorities constituted under the PNDT Act to prohibit sex selection techniques and its advertisement throughout the country;

b) direct that the appropriate authorities shall also include "vehicles" with ultra sound machines etc., in their quarterly reports hereinafter as defined under Section 2(d);

c) any person or institution selling Ultra Sound machine should provide information to the appropriate State Authority in furtherance of Section 3-B of the Amended Act;

d) direct that State Supervisory Boards be constituted in accordance with the amended Section 16A in order to carry out the functions enumerated therein;

e) direct appropriate authorities to initiate suo moto legal action under the amended Section 17(iv)(e);

f) direct that the Central Supervisory Board shall publish half yearly consolidated reports based on the quarterly reports obtained from the State bodies. These reports should specifically contain information on:

1) Survey of bodies and the number of bodies registered.

2) Functioning of the regulatory bodies providing the number and dates of meetings held.

3) Action taken against non-registered bodies inclusive of search and seizure of records.

4) Complaints received and action taken pursuant thereto.

5) Nature and number of awareness programmes.

6) Direct that the Central Supervisory Board shall carry out all the additional functions as given under the amended Section 16 of the Act, in particular, to oversee the performance of various bodies constituted under the Act and take appropriate steps to ensure its proper and effective implementation.

As against this, Mr. Mahjan learned counsel appearing for the Union of India submits that on the basis of the aforesaid amendment, appropriate action has already been taken by Union of India for implementation and almost all State Governments/UTs are informed to implement the said Act and the Rules and the State Governments/UTs are directed to submit their quarterly report to the Central Supervisory Board.

Considering the amendment in the Act, in our view, it is the duty of the Union Government as well as the State Governments/UTs to implement the same as early as possible."

…

12. In view of the various directions issued by this Court, as quoted above, no further directions are required except that the directions issued by this Court on 4th May,

2001, 7th November, 2001, 11th December, 2001 and 31st March, 2003 should be complied with. The Central Government / State Governments / UTs are further directed that:

a) For effective implementation of the Act, information should be published by way of advertisements as well as on electronic media. This process should be continued till there is awareness in public that there should not be any discrimination between male and female child.

b) Quarterly reports by the appropriate authority, which are submitted to the Supervisory Board should be consolidated and published annually for information of the public at large.

c) Appropriate authorities shall maintain the records of all the meetings of the Advisory Committees.

d) The National Monitoring and Inspection Committee constituted by the Central Government for conducting periodic inspection shall continue to function till the Act is effectively implemented. The reports of this Committee be placed before the Central Supervisory Board and State Supervisory Board for any further action.

e) As provided under Rule 17(3), public would have access to the records maintained by different bodies constituted under the Act.

f) Central Supervisory Board would ensure that the following States appoint the State Supervisory Board as per the requirement of Section 16A.

   1. Delhi 2. Himachal Pradesh 3. Tamil Nadu 4. Tripura 5. Uttar Pradesh.

g) As per requirement of Section 17(3)(a), the Central Supervisory Board would ensure that the following States appoint the multi-member appropriate authorities:
   1. Jharkhand 2. Maharashtra 3. Tripura 4. Tamil Nadu 5. Uttar Pradesh

It will be open to the parties to approach this Court in case of any difficulty in implementing the aforesaid directions.

…

# Voluntary Health Association of Punjab (VHAP) v. Union of India & Ors., Supreme Court W.P. (C) 349/2006

## Synopsis

Despite numerous laws and regulations preventing sex selection, the sex ratio in India has continued to decline. In some areas, the sex ratio is as low as 870 girls to 1000 boys. In spite of the Court's previous order that States take action to implement the Pre-Conception & Pre-Natal Diagnostic Techniques Act (order in *CEHAT v. Union of India*), State governments have not taken sufficient steps to balance India's sex ratio.

### Facts

Following India's 2001 census, many civil society groups noted with alarm that the sex ratio in the 0 to 6 year age group had sharply declined, particularly in prosperous states like Punjab and Haryana. Although the Supreme Court ordered implementation of the PC & PNDT Act in a 2000 decision, states have largely ignored the Court's orders. Subsequently, HRLN filed this petition in the Supreme Court seeking stricter implementation of the PC & PNDT Act.

### Relevant Law

*Cases*: *CEHAT v. Union of India*
*Statutes & Schemes*: The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994

## Outcome

As of today, the Court has encouraged the petitioners and the government to work jointly to solve the problem of sex selection. Taking the initiative, HRLN organized a National Consultation with several other civil society groups to develop strategies to combat sex selection. The matter is still pending.

## Orders

### November 12, 2010

We are of the view that this matter cannot be treated as adversarial in nature. We are confident that, with the able assistance of the learned Additional Solicitor General, many of the points involved in these writ petitions could be resolved. We recommend that a meeting be arranged between the Government and the petitioners so that the issues involved in these writ petitions would stand resolved amicably.

…

# Sterilization

## Ramakant Rai v. Union of India, Supreme Court W.P. (C) 209/2003

### Synopsis

In *Ramakant Rai*, the Supreme Court ordered State governments to take immediate steps to regulate health-care providers who perform sterilization procedures, and to compensate women and families of women who suffer complications or death as a result of unsafe sterilizations.

### Facts

The petitioners conducted surveys and reports that reveal the appalling conditions in Government-run sterilisation centres. Throughout India, government health workers fail to respect the basic dignity of their patients. In many cases, before the surgery commences doctors fail to counsel women, outline alternative forms of birth control, or warn their patients about the dangers associated with the operation. False promises and monetary incentives are also used to lure women into sterilization. In addition, under-qualified staff frequently performs pelvic checks and sterilization surgeries often resulting in serious infection or death, male doctors pass indecent comments, and public health facilities do not respect privacy or confidentiality.

Further, there are significant problems with hygiene in public facilities. Public health centres and sterilization camps typically lack basic amenities such as electricity and medical equipment. Surgery is commonly performed on the floor or on broken or slanting tables, often still covered with the blood of previous operations. At camps, a single doctor will often perform up to 50 procedures a day, when the prescribed limit is 20. Moreover, needles are reused on many patients. Post-surgery, women are discharged with septic stitches and receive neither a proper examination nor post-operative instructions, monitoring or counseling. These appalling conditions have resulted in numerous post-operative complications, intense mental and physical trauma for the women involved, and in some cases even death.

### Relevant Law

None cited

## Outcome

In light of the lack of uniformity amongst State regulations governing sterilization procedures as well as State's failure to comply with national guidelines, the Supreme Court examined best practices of some States and directed all States to do the following: (1) introduce a system to limit procedures to approved doctors with specified experience/credentials; (2) prepare a checklist to be filled out for each patient prior to any procedures; (3) circulate uniform copies of the proforma of consent; (4) establish a Quality Assurance Committee to ensure that guidelines are followed in respect of pre-operative measures, operational facilities and post-operative follow ups, and to collect and publish reports on the number of persons sterilized, deaths or complications arising out of the sterilization; (5) maintain statistics on patients, procedures, and outcomes for sterilization carried out in the state; (6) inquire into cases where national guidelines have been breached and take punitive action against any doctor or organization; and (7) establish an insurance policy per national guidelines.

The Supreme Court directed the Union of India to lay down uniform standards to be followed by the State Governments with regard to the health and age of proposed patients, norms for compensation, the format of statistics, the check list, consent proforma, and insurance. Until such time as the Union of India proscribes guidelines governing compensation, the Supreme Court directed States to pay Rs. 1 lakh in case of the 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 a sum of Rs. 20,000/-.

## Judgment

### DATE

…

Several states have filed affidavits setting out the steps taken by them to regulate sterilization procedures … in their respective states. However, it is apparent that there is no uniformity with regard to the procedures nor the norms followed for ensuring that the guidelines laid down by the Union of India in this regard are being followed. Taking the best of what is being followed by some states, we direct that the states shall:

(1) 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…. The panel may be prepared either state-wise, District-wise, or Region-wise basis. The criteria for including the names of the doctors on such panel must be laid down by the Union of India as indicated subsequently. Until the Union of India lays down

uniform qualification criteria for the empanelment of doctors, for the time being no doctor without gynecological training for at least 5 years post degree experience should be permitted to carry out the sterilization programmes.

(2) The State Government shall also prepare and circulate a checklist which every doctor will be required to ill in before carrying out a 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

(3) The state Governments shall also circulate uniform copies of the proforma of consent. Until the Union Government certifies such proforma, for the time being, the proforma as utilized in the State of U.P., shall be followed by all the States; and

(4) Each States shall set up a Quality Assurance Committee which should, as being followed by the State of Goa, 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 (for example, by way of pathological tests, etc.), operational facilities (for example, sufficient number of necessary equipment and aseptic conditions) and post-operative follow ups. It shall be the duty of the Quality Assurance Committee to collect and publish six monthly reports of the number of persons sterilized as well as the number of deaths or complications arising out of the sterilization.

(5) Each State shall also maintain overall statistics giving a break up of the number of the sterilizations carried out, particulars of the procedure followed (since we are given to understand that there are different methods of sterilization), 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, and the number of persons incapacitated by reason of the sterilization programmes.

(6) The State Government shall not only hold an enquiry into every case of breach of the Union of India guidelines by any doctor or organization but also take punitive action against them. As far as the doctors are concerned, their names shall, pending enquiry, be removed from the list of empanelled doctors.

(7) The state shall also bring into effect an insurance policy according to the format followed by the state of Tamil Nadu until such time as the Union of India prescribes a standard format.

(8) The Union of India shall lay down within a period of four weeks from date uniform standards to be followed by the State Governments with regard to the health of the proposed patients, the age, the norms for compensation, the format of the statistics, check list and consent proforma and insurance.

(9) 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 government formulates the norms of compensation, the State shall follow the practice of the State of Andhra Pradesh and shall pay Rs. 1 lakh in case of the 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 a sum of Rs. 20,000/-.

All the States have responded except the State of Jammu and Kashmir. Needless to say that the State of Jammu and Kashmir will also follow this order.

Let the matter be placed eight weeks later by which time the Union Government and State Governments should indicate the steps taken by them in compliance of this order.

# Devika Biswas v. Union of India & Ors., Supreme Court W.P. (C) 95/2012

## Synopsis

In spite of the Supreme Court's orders in *Ramakant Rai*, forced and unsanitary sterilisations 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, a sterilization camp was held at a government middle school in the Araria District of Bihar. An NGO performed the camp in a government middle school notwithstanding government guidelines specifically forbidding sterilization camps in schools. Under torch light at night, one doctor and a handful of untrained NGO volunteers sterilized 53 women in only two hours. No water was available to sanitize equipment or to hydrate patients. Further, all patients were put under general anesthesia instead of local, at great risk to their health.

The sterilized women woke up in pain and covered in blood while the untrained medical staff provided only expired pain medicine before fleeing. In spite of the shocking violations that occurred at this camp, the government praised the results and stated that the only noticeable problem was the expired pain medicine. Despite the specific orders laid down by the Apex Court in *Ramakant Rai*, sterilisations continue throughout India without basic medical standards, including informed patient consent. Devika Biswas, a health activist from Bihar, filed this petition seeking further oversight of this practice from the Court and enforcement of the orders issued in *Ramakant Rai*. Since HRLN initially filed the case, stories of unsafe and unethical sterilization camps have emerged from across India.

### Relevant Law

*Constitution:* Article 21 (right to a dignified life)
*Cases*: *Ramakant Rai v. Union of India*, Supreme Court W.P. 209/2003

## Outcome

The case was filed in mid-2012, and is still pending.

The Human Rights Law Network (HRLN) is a collective of lawyers and social activists dedicated to using the legal system to advance human rights 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.


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