CHAPTER TEN

MATERNAL HEALTH

Maternal health, meaning the "*health of women during pregnancy, childbirth and the postpartum period*,"[1] has been recognized by Indian courts as being protected by the right to health, which is a facet of right to life under Article 21 of the Indian Constitution.[2] The Constitution also mandates the State to provide maternity relief to women under Article 42, which has been interpreted to include providing adequate maternal health services.[3] Indian courts have also relied upon international human rights instruments to understand the scope of this right, and the corresponding obligations upon the State. In keeping with these obligations, the State has put in place various schemes and structures for providing maternal health services, especially to impoverished women. Despite these, women face routine denials or lack of access to effective maternal health care services. In this chapter we analyze courts' responses to such denial of access. We note here that High Courts across the country are engaged in adjudicating cases relating to denial of access to maternal healthcare services. However, many such cases are ongoing and as yet contain no substantive orders laying down any jurisprudence or provide any substantive remedy beyond seeking a reply or a compliance report from the State.[4] Such cases have not been included in the Compendium.

A case that highlights both the articulation of the right to maternal health, as well as the Court's response to the violation of this right, is ***Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors***.[5] This case involved two petitions before the Delhi High Court challenging the government's failure to ensure that pregnant women are able to access essential services and entitlements guaranteed under various government benefit schemes.[6] The two petitions also sought accountability for the denial of access to minimum health care to two women during the critical weeks preceding their delivery at home and in public health institutions, causing the maternal death of one of them. Locating these schemes within a matrix of constitutional and international human rights obligations of the State, the High Court reiterated that the right to health (including the right to access and receive a minimum standard of treatment and care in public health facilities), the reproductive rights of women, and the right to food are inalienable survival rights forming part of the right to life. Based on this understanding, the Court held that a pregnant woman should not be denied treatment at any stage irrespective of her social and economic status, or on the basis of her failure to produce appropriate identification documents. The Court also questioned the rationality of denying certain forms of assistance to women beyond two live births in a social milieu where women often have little choice as to whether to have a third child or not. Further, the Court issued a number of directions for strengthening the implementation of these schemes, such as directing the State to provide safe and prompt transportation to and from health care facilities for pregnant women.

Similarly, in ***Sandesh Bansal v. Union of India***,[7] the petitioners highlighted the poor implementation of the National Rural Health Mission (NRHM) in Madhya Pradesh and the state government's failure to meet its goal of reducing the maternal mortality ratio (MMR). The NRHM aims at improving public health in rural areas and seeks to provide accessible, affordable and quality health care to the rural population. It also seeks to reduce the MMR. Stating that inability to survive through pregnancy and childbirth violates women's right to life under Article 21 of the Indian Constitution, the High Court of Madhya Pradesh recommended a number of measures to be undertaken by the state to ensure public health care centres are able to provide round the clock quality maternal health care services, including proper sanitation and uninterrupted electricity and water at health centres, adequate staffing at sub- and primary health centres, and 24-hour availability of community health workers at the Panchayat level. The Court also directed that state community health centres should be equipped with 30-50 beds and required staff and should provide 24 hours delivery services.

In ***Rinzing Chewang Kazi v. State of Sikkim***,[8] a public interest litigation was filed before the High Court of Sikkim seeking effective implementation of NRHM in the state. The Court, *inter alia*, directed that the Janani Suraksha Yojana and Janani Shishu Suraksha Karyakaram should be implemented in their letter and spirit. It also passed directions for regular maternal death reviews and community-based monitoring and for uploading necessary materials in this regard on the website of National Health Mission.

In ***People's Union for Civil Liberties v. Union of India (Right to Food case)***,[9] petitioners questioned the legality of discontinuing the National Maternity Benefit Scheme (NMBS), including the cash benefit provided under it, and introducing the Janani Suraksha Yojana instead. In adjudicating this issue, the Supreme Court directed the state to continue the NMBS scheme and provide cash assistance to pregnant women irrespective of their age and number

of children. However, the Court also directed the Union of India to consider whether the grant of such a benefit regardless of the number of children and age of the pregnant woman went against the national population policy and the prohibition of child marriage.[10]

A Division Bench of the High Court of Delhi in ***Court on Its Own Motion v. Union of India***,[11] initiated a *suo motu* public interest litigation based on a news report about the death of a destitute woman after giving birth to a child on the street. Holding that the Court cannot be a "silent spectator" when the inaction of the Government was leading to the deaths of destitute pregnant and lactating women on the streets, the Court issued several directions to protect destitute pregnant and lactating women, which included setting up of shelter homes and provision of medical facilities and mobile medical units for them.

The High Court of Chhattisgarh in ***Kali Bai v. Union of India***,[12] was approached by a woman whose pregnant daughter died due to inadequate facilities and mismanagement at a public health facility where she was admitted for delivery. The Court held that the right to health includes the right to access public health facilities and the right to a minimum standard of treatment and care through such facilities. Noting that such right to health and the reproductive rights of women are inalienable components of Article 21, the Court emphasized that the identification of high-risk pregnancies, and the prompt referral of cases needing specialist care to institutions equipped to provide the same, were "indefensible components of access to protection and enforcement of reproductive rights." To secure the implementation of these rights, the Court issued directions for the improvement of public health facilities, particularly the provision of emergency obstetric care.

These cases highlight that courts have been proactive in both recognizing the right to maternal health as a fundamental right, and in directing and overseeing the proper implementation of existing schemes for securing maternal health.

Related Human Rights Standards and Jurisprudence

Below is a selection of human rights standards and jurisprudence relating to state obligations to ensure the rights of women and girls to appropriate care related to pregnancy and childbirth. Human rights mechanisms have emphasized that states have a duty to ensure that comprehensive maternal health care, including pre-, peri- and post-natal care, are available, affordable, accessible, and of good quality. States must also take steps to create a social and cultural environment conducive to realizing women's rights to reproductive and maternal health, free from discrimination.

The Government of India has committed itself to comply with obligations under various international human rights treaties to protect sexual and reproductive health and rights. These include the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW), and the International Covenant on Civil and Political Rights (ICCPR).[13] Under international law all government organs and authorities, including the judiciary, are obligated to uphold the laws and standards outlined in these treaties.[14] The Supreme Court has held that in light of the obligation to "foster respect for international law" in Article 51 (c) of the Indian Constitution, "[a]ny International Convention not inconsistent with the fundamental rights and in harmony with its spirit must be read into [fundamental rights] to enlarge the meaning and content thereof, to promote the object of the constitutional guarantee."[15]

INTERNATIONAL TREATY STANDARDS

TREATIES

- **ICESCR, Articles 2(2), 3, 10(2), 12** (prohibiting sex-based discrimination; guaranteeing the right to health, including access for all to medical service when ill).
- **ICCPR, Articles 2(1), 3, 5, 6, 17** (guaranteeing the equal rights of men and women and prohibiting discrimination on the basis of sex; protecting the rights to life and privacy, to found a family, and to equality between spouses).

- **CEDAW, Articles 1-4, 5(b), 9(2), 10(h), 11(2), 12, 13(1), 14(2)(b), 16(e)** (guaranteeing women's rights to equality irrespective of marital status, to health, and to determine the number and spacing of children; specifying that the state must "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" and extend all human rights, including access to health care, to rural women).
- **Convention on the Rights of the Child**, **Articles 24(2)(a), 24(2)(d)–(f), 24(4)** (outlining that States must "ensure appropriate pre-natal and post-natal health care for mothers", strive to reduce infant and child mortality, develop family planning education and services that teach the advantages of breastfeeding, and cooperate internationally between countries in order to realize these goals).

SELECTED GENERAL COMMENTS

- **Committee for Economic Social and Cultural Rights (CESCR), *General Comment No. 22 (2016) on the right to sexual and reproductive health,*** U.N. Doc. E/C.12/GC/22 (2016), paras. 9-21, 27-28, 45, 48, 57 (providing that sexual and reproductive health care, including maternal care, must be available, accessible, acceptable and of good quality including to adolescents; and obliging states to eliminate social misconceptions, prejudices and taboos concerning pregnancy and childbirth and to guarantee access to maternal health care, emergency obstetric care, and skilled birth attendants, including in rural areas and for marginalized groups).
- **CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12),*** U.N. Doc. E/C.12/2000/4 (2000), paras. 12, 14, 21, 44(a), 52 (outlining that the right to health entitles individuals to available, accessible, acceptable and good quality health care information, facilities, goods and services on a basis of non-discrimination; requiring states to take "measures to improve child and maternal health, […] 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;" and highlighting that in order to eliminate discrimination against women, states should aim to reduce maternal mortality and morbidity, remove all barriers to access health services and information, and prevent and remediate harmful traditional practices).
- **CEDAW Committee, *General Recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19,*** U.N. Doc. CEDAW/C/GC/35 (2017), paras. 12, 18, 20, 38, 40(c) (recognizing that "abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services […], depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment").
- **CEDAW Committee, *General Recommendation No. 34 on the rights of rural women***, U.N. Doc. CEDAW/C/GC/34 (2016), paras. 38-39 (calling on states to safeguard maternal health for rural women).
- **CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health),*** U.N. Doc. A/54/38/Rev.1, chap. I (1999), paras. 9-15, 17, 20-22, 26-31 (describing state duties to ensure access to health care that respects the rights to informed consent, autonomous decision-making, and freedom from discrimination, and to ante-, peri- and post-natal care, including to free care where necessary; requiring states to budget adequately for women's health needs; outlining that health care systems are discriminatory if they lack services to prevent and treat health conditions specific to women, with consideration for biological as well as socioeconomic differences affecting women; and detailing that high maternal mortality and morbidity rates indicate a breach of state duties).
- **Committee on the Rights of the Child (CRC), *General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence,*** U.N. Doc. CRC/C/GC/20 (2016), paras. 13, 27, 55, 59-60 (recognizing childbirth as a preventable cause of adolescent mortality and morbidity; outlining that states should ensure adolescents access to free, confidential, adolescent-responsive and non-discriminatory maternity and other reproductive health services). *See also* **CRC, *General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child, contained in*** U.N. Doc. CRC/GC/2003/4 (2003), para. 27.
- **CRC, *General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (article 24),*** U.N. Doc. CRC/C/GC/15 (2013), paras. 43-44, 51-57 (outlining states' obligation to respond to the health needs and rights of expectant and new mothers, including adolescent mothers, to nutrition, the monitoring of health conditions such as eclampsia and pre-eclampsia, and pre-, peri- and post-natal health care).

- **Human Rights Committee (HRC),** ***General comment No. 36 (2018) on article 6 of the ICCPR on the right to life***, U.N. Doc. CCPR/C/GC/36 (2018), paras. 8, 26 (outlining that the right to life requires ensuring the availability and accessibility of quality prenatal health care on a confidential basis and includes ensuring access to medical examinations and treatments designed to reduce maternal mortality).

INQUIRIES AND INDIVIDUAL COMPLAINTS

- **CEDAW Committee,** ***Alyne da Silva Pimentel Teixeira v. Brazil***, **Communication No. 17/2008**, U.N. Doc. CEDAW/C/49/D/17/2008 (2011), paras. 7.1-8 (in a case where an Afro-Brazilian woman died due to negligent medical care during pregnancy: holding the state responsible for upholding women's access to health care even when it delegates medical care to private institutions; finding that the violations of her rights to reproductive health and life also constituted discrimination on the basis of sex, race and socioeconomic class; and instructing the state to pay reparations, to ensure proper training and funding for medical institutions and personnel, and to ensure access to effective remedies where violations occur).

UNITED NATIONS HUMAN RIGHTS EXPERT AND WORKING GROUP REPORTS

- **Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (SR Health),** ***Report of the SR Health***, U.N. Doc. E/CN.4/2004/49 (2004), paras. 14, 18, 29-31, 39, 41-44 (defining the right to reproductive health to include the right of access to maternal health care services, including services and information on family planning, pre- and post-natal care, and emergency obstetrics, and that such care must be cost-free where necessary, available in rural areas, based on informed consent and free of coercion, violence and discrimination).
- **SR Health,** ***The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Note by the Secretary-General***, U.N. Doc. A/60/348 (2005), paras. 8-9, 11, 15-16, 52-53 (outlining that the right to health includes the rights to maternal health and to care free from discrimination, as well as to effective accountability mechanisms that uphold these rights).
- **Working Group on the issue of discrimination against women in law and in practice,** ***Report of the Working Group on the issue of discrimination against women in law and in practice***, U.N. Doc. A/HRC/32/44 (2016), paras. 23, 26-34, 37-39, 61-64, 72, 74-75, 79, 89, 105-108 (outlining that in order to realize women's equality, states must ensure non-discriminatory, timely access to affordable, quality maternal health care, and protection from degrading treatment and violence both in and outside health care settings; calling on states to address intersectional discrimination faced by vulnerable subgroups of women, end discriminatory practices such as the criminalization of abortion and policies such as a lack of public funding or restrictive insurance coverage that undermine affordable access to health care services that only women need; and urging states to refrain from restrictive views of maternal health that ignore broader women's health needs such as access to nutrition throughout pregnancy and breastfeeding and the right to decide the circumstances of childbirth).

REGIONAL CASE LAW

EUROPEAN COURT OF HUMAN RIGHTS

- ***Konovalova v. Russia,*** **Application No. 37873/04 (2015)**, paras. 39-50 (where a woman giving birth was observed by medical students who also had access to her medical records, without the opportunity for her to give or withhold her consent: finding a violation of the right to private life).

INTER-AMERICAN COURT OF HUMAN RIGHTS

- ***Xákmok Kásek Indigenous Community v. Paraguay*****, Series C No 214, Merits, Reparations, and Costs (2010)**, paras. 231-234 (where the state's severe neglect of an indigenous community led to, *inter alia*, a woman's death after childbirth: underscoring that extreme poverty and lack of pre- and post-natal care leads to high maternal mortality and morbidity; holding that states must design health care policies to ensure that adequately trained medical personnel are able to prevent maternal mortality through adequate pre-, peri- and post-natal care, and ensure that cases of maternal mortality are adequately documented; and finding, *inter a*lia, a violation of the right to life).

RELEVANT EXCERPTS FROM SELECT CASE LAW

(Arranged chronologically)

IN THE SUPREME COURT OF INDIA

People's Union for Civil Liberties v. Union of India
(2009) 16 SCC 149
Arijit Pasayat and S.H. Kapadia, JJ.

Through an earlier order in this case, the Supreme Court had directed that the National Maternity Benefit Scheme (NMBS) shall not be discontinued or restricted without its prior approval. The Union of India filed an interim application seeking permission to modify the NMBS and introduce a new scheme called Janani Suraksha Yojana (JSY). The People's Union for Civil Liberties (PUCL) filed an application questioning the legality of the discontinuation of the cash benefit under NMBS pursuant to introduction of JSY. The Court ruled that the benefits under the NMBS should continue and cash assistance should be provided to women who are below poverty line, irrespective of their age and number of children. Meanwhile, the Court directed Union of India to consider if the grant of such benefit would go against the national population policy.

Pasayat, J.: "By this order two IAs Nos. 37 of 2004 and 54 of 2005 stand disposed of. IA No. 37 of 2004 is an application by the Union of India for permission to modify the National Maternity Benefit Scheme (in short "NMBS") and to introduce a new scheme called Janani Suraksha Yojana (in short "JSY"). IA No. 54 of 2005 is an application by the petitioner questioning legality of the discontinuation of the benefit under NMBS due to introduction of JSY. By order dated 27-4-2004 [*People's Union for Civil Liberties* v. *Union of India*, (2009) 16 SCC 598] this Court directed as follows:

> "No Scheme … in particular … National Maternity Benefit Scheme shall be discontinued or restricted in any way without prior approval of the Court."

2. Again, by order dated 9-5-2005 [*People's Union for Civil Liberties* v. *Union of India*, (2009) 16 SCC 614] this Court directed as follows:

> "By IA No. 37, permission is sought to modify the National Maternity Benefit Scheme (NMBS) and to introduce a new scheme, namely, Janani Suraksha Yojana (JSY). Whereas in IA No. 54, the prayer is that the Scheme should not be modified by reducing, abridging or qualifying in any way the social assistance entitlements created under the original scheme of NMBS for expecting BPL mothers, including cash entitlement of Rs 500 provided therein. We have requested learned Additional Solicitor General to place on record further material in the form of affidavit to effectively implement the new Scheme sought to be introduced. The further material shall include the approximate distance of Public Health Centre from the residential complexes and the facility of transportation, etc. The Commissioner shall also examine the matter in depth and file a report. The response to the application may be filed within eight weeks. Meanwhile, the existing National Maternity Benefit Scheme will continue."

3. The Government set a numerical ceiling of 57.5 lakh beneficiaries as the annual target for NMBS. However, the number of beneficiaries under JSY in 2006-2007 was only 26.2 lakhs i.e. 45.5% and in the year 2005-2006 this was as low as 5.7 lakhs i.e. 10%. …

4. According to the Union of India, JSY was introduced to put a premium on the willingness of poor women to go in for institutional delivery instead of home delivery. But it was recognised that in the States with lower institutional delivery rates, one of the reasons for low performance have been lesser availability of facilities in the health centres, which acts as disincentive for the poor illiterate women to seek the services.

5. Pursuant to the order of this Court dated 9-5-2005 [*People's Union for Civil Liberties* v. *Union of India*, (2009) 16 SCC 614] the Commissioner had prepared a report.

6. After discussions with the Commissioner appointed by this Court, senior officials of the Central Government took a decision to modify JSY Scheme to continue benefits of NMBS and also to improve upon such benefits for non-institutional delivery, where the woman chooses to deliver her baby at home…

7. The table below gives details of the number of beneficiaries under JSY (all these would have received Rs 500 under NMBS irrespective of place of delivery) vis-à-vis the annual targets set by the Government of India for NMBS: …

8. The Scheme as the details above go to show has virtually not taken off in many States.

...

10. At this juncture, the financial performance needs to be noted.

11. Janani Suraksha Yojana is a Centrally sponsored scheme with the Centre providing 100% of the funds. Some States e.g. Andhra Pradesh make their own contribution thereby increasing the amount of cash assistance for institutional deliveries. Tamil Nadu has introduced a separate scheme for providing mothers with Rs 1000 per month for six months i.e. three months prior to the delivery and three months after.

…

13. … Only ten States spent more than 70% of the funds allocated to them under JSY.

14. At the time of hearing of the applications, learned counsel for the petitioner and the Union of India highlighted various aspects. Considering the submissions and the material data placed on record we direct as follows:

(*a*) The Union of India and all the State Governments and the Union Territories shall (*i*) continue with 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 woman.

(*c*) The Union of India, the State Governments and the Union Territories shall file affidavits within 8 weeks from today indicating the total number of births in the State, number of eligible BPL women who have received the benefits, number of BPL women who had home/non-institutional deliveries and have received the benefit, number of BPL women who had institutional deliveries and have received the benefit.

(*d*) The total number of resources [*sic* are] allocated and utilised for the period 2000-2006.

(*e*) All Governments concerned are directed to regularly advertise the revised scheme so that the intended beneficiaries can become aware of the Scheme.

(*f*) The Central Government shall ensure that the money earmarked for the Scheme is not utilised for any other purpose. The mere insistence on utilisation certificate may not yield the expected result.

(*g*) 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 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.

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.

16. The IAs are accordingly disposed of."

IN THE HIGH COURT OF DELHI

Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors.
and
Jaitun v. Maternal Home MCD Jangpura
(2010) 172 DLT 9
S. Muralidhar, J.

The two writ petitions sought redress for the denial of benefits to two women during their pregnancy and immediately thereafter, 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). The petitions sought to highlight systemic failures and shortcomings in the implementation of this cluster of schemes for reducing infant and maternal mortality. The Delhi High Court considered whether pregnant women needing healthcare can be denied access to public health facilities due to failure to establish eligibility under government schemes. The Court also considered whether Article 21 of the Indian Constitution guarantees the right to reproductive health and reproductive rights of pregnant women.

Muralidhar, J.: "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) during their pregnancy and immediately thereafter, 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. Although the chief protagonists in the two petitions are the two mothers and their babies, the petitions highlight the gaps in implementation that affect a large number of similarly placed women and children elsewhere in the country. The petitions reveal the unsatisfactory state of implementation of the schemes in the two "high performing states" of Haryana and the National Capital Territory of Delhi (NCT of Delhi). 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 OF THE JSY

3. Before discussing the facts of the two cases, it is necessary to have a brief overview of the prevalent Schemes, both centrally and state sponsored, for reducing infant and maternal mortality, which in terms of many documented studies is acknowledged as being high in India.

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

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

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

2. Assist the pregnant woman to obtain necessary certifications wherever necessary, within 2-4 weeks of registration.

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

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

5. Counsel for institutional delivery.

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

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

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

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

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

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

6. A child under the JSY is entitled to:

1. Emergency care of sick children including Integrated Management of Neonatal and Childhood Illness (IMNCI)

2. Care of routine childhood illness

3. Essential Newborn Care

4. Promotion of exclusive breastfeeding for 6 months.

5. Full immunization of all infants and children against vaccine preventable diseases as per guidelines of GOI

6. Vitamin A prophylaxis to the children as per guidelines

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

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 disbursement is made at the time of delivery. Cash assistance of Rs. 700 in case of rural and of Rs. 600 in case of urban is given for institutional delivery and of Rs. 500 is given for home delivery. In rural areas, cash assistance for referral transport to go to the nearest health centre for delivery is provided. The JSY identifies only 10 States as low performing States ('LPS') and the remaining as high performing states ('HPS'). What is to be borne is mind however is that the cash incentive is but one component of the JSY.

…

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

> **12.** The objectives of the Integrated Child Development Services (ICDS) Scheme, which was launched in 1975, are:
>
> 1. to improve the nutritional and health status of children in the age-group 0-6 years;
>
> 2. to lay the foundation for proper psychological, physical and social development of the child;
>
> 3. to reduce the incidence of mortality, morbidity, malnutrition and school dropout;
>
> 4. to achieve effective co-ordination of policy and implementation amongst the various departments to promote child development; and
>
> 5. to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

…

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

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

16. On 2nd May, 2003, the Supreme Court directed the Government of India to place on AAY category the following groups of persons:

> "(1) Aged, infirm, disabled, destitute men and women, pregnant and lactating women, destitute women;
>
> …"

…

THE NRHM

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

- Early registration of pregnancy before 12th week of pregnancy
- Minimum of 4 antenatal check ups first—when pregnancy is suspected, second—around 26 weeks of pregnancy, third—around 32 weeks, fourth—around 36 weeks
- Associated services like general examination such as weight, BP, anaemia, abdominal examination, height and breast examination,
- Injection Tetanus Toxoid, treatment of anaemia, etc. (as per the Guidelines for Antenatal care and Skilled Attendance at Birth by ANMs and LHVs)
- Minimum laboratory investigations like haemoglobin, urine albumen and sugar.
- Identification of high-risk pregnancies and appropriate and prompt referral
- Counselling.
- Folic acid supplementation in the first trimester
- Iron and Folic Acid supplementation from twelve weeks,
- Skilled attendance at home deliveries as and when called for
- A minimum of 2 postpartum home visits. First within 48 hours of delivery, second within 7-10 days.
- Initiation of early breast-feeding within half hour of birth
- Counselling on diet and rest, hygiene, contraception, essential new born care, infant and young child feeding. (As per Guidelines of GOI on Essential newborn care) and STI/RTI and HIV/AIDS
- Education, Motivation and Counselling to adopt appropriate Family planning methods,
- Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions (Wherever the ANM is trained on IUD insertion)
- Counselling and appropriate referral for safe abortion services (MTP) for those in need.
- Appropriate and prompt referral of cases needing specialist care
- Essential Newborn Care
- Promotion of exclusive breast-feeding for 6 months.
- Full Immunization of all infants and children against vaccine preventable diseases as per guidelines of GOI
- Vitamin A prophylaxis to the children as per guidelines. Prevention and control of childhood diseases like malnutrition, infections, etc.

19. 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

20. 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.

21. 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.

22. 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.

23. 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. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.

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.

24. 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."

25. 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

> …
>
> 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:
>
> …
>
> (b) To have access to adequate health care facilities, including information, counselling and services in family planning;
>
> …

26. 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.

…

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.

…

27. 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."

28. 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.

…

ANALYSIS OF FACTS

37. 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 socioeconomic 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. The findings of Dr. Prakasamma have already been referred to earlier.

38. Dr. Prakasamma'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.

39. In neither of the cases of Fatema or Shanti Devi were the substantive benefits under the JSY schemes made available. In *Fatema's case*, as the hearing of these cases progressed, the GNCTD incrementally came up with documents 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.

40. 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.

41. 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.

42. 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. It was either too little or too late. 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.

43. 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 caesarean operation in which case she also would be required to move to the Government Health Centre with such facilities without delay.

44. …Be that as it may, given that an important component of the JSY is counselling 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*.

45. 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

46. 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.

47. 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."

48. 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.

49. 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.

50. 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 centres 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.

51. 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.

52. 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

53. 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. It may be recalled that she miscarried the child during her fifth pregnancy and the dead foetus had to be removed almost a week later in the institution. The constant monitoring and care envisaged by the JSY was completely absent in her case on both the occasions.

54. 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.

55. 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.

56. In the case of *Fatema* soon after the baby was delivered, she required nutrition and supplements which were denied till 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.

57. 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.

58. 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.

…

59. 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.

60. 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…

61. 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-II	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"

62. 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.

63. 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

64. 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 checkup.

(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

65. 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.

66. 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.

67. 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 counselling 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.

68. 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.

69. Likewise, there should be a constant review and monitoring under the ICDS as well. This will involve setting up of the Aanganwadi Centres in terms of the directions by these two States for themselves.

70. 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.

71. 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

72. The GNCTD, the State of Haryana and the Union of India will file affidavits by way of compliance with respect to above directions in this Court within eight weeks.

…"

IN THE HIGH COURT OF DELHI

Court on Its Own Motion v. Union of India
2011 SCC OnLine Del 137
Dipak Misra, C.J., and Sanjiv Khanna, J.

A suo motu public interest litigation was initiated by the Delhi High Court on the basis of a newspaper report that stated that a destitute woman died after giving birth to a child on the street. The court passed directions for extending protection and health care facilities to destitute pregnant and lactating women.

Misra, C.J. and Khanna, J.: "The present public interest litigation was initiated suo motu by this Court taking into consideration a newspaper report dated 29th August, 2010 published in the 'Hindustan Times' that a destitute woman breathed her last on a busy street after giving birth to a baby girl, namely, Karishma who had been struggling for life at a foster home, namely, 'Udayan'.

The matter was dealt with to some extent on 1st September, 2010 and how important and significant the life of a child who forms the vertebra of a spine of the nation and the role of the mother in building the nation.

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: -

"(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."

… In the counter affidavit, many an assertion has been made but on a perusal of the same, it transpires that 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.

…

…[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, may be after giving birth to a child or may be along with the child. Such a situation cannot be countenanced and is not possible to visualize in the backdrop of Article 21 of the Constitution of India. It is expected of the State and the persons who are in-charge of its departments to have a vision. It has been said long back that the personalities who have vision can always visualize the invisibility. To elaborate: it conveys the situation which exists and are likely to eloquently get edificed, must be pursued by the persons who are in the helm of administration.

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 recalcitrant, 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.

..."

IN THE HIGH COURT OF MADHYA PRADESH

Sandesh Bansal v. Union of India
W.P. No. 9061/2008 (Order dated February 6, 2012)
Ajit Singh and Sanjay Yadav, JJ.

This public interest litigation challenged the State of Madhya Pradesh's failure to meet its goal of reducing maternal mortality due to shortcomings in the implementation of the National Rural Health Mission (NRHM). The High Court considered the constitutional obligation of the state to implement NRHM to ensure women's survival during pregnancy and childbirth under Article 21.

Yadav, J.: "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 causality accounting 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 live births by focusing on following measures:

> (i) strengthening the health care infrastructure construction / upgradation of Primary Health Centre (PHC)/Community Health Centre (CHC)/District Hospitals etc. to enable early detection of higher risk pregnancies and provide iron and folic acid to correct anemia and tetatus toxoid immunization and emergency obstetric care, and to provide these institutions with united funds to improve their services.
>
> (ii) promoting institutional deliveries through the Janani Suraksha Yojna (hereafter shall be referred to as JSY), whereby women who have three antenatal check-ups and deliver in health, institutions are paid Rs.1400 and their motivators Rs.600/- in rural areas and Rs.1200 and Rs.400 respectively in urban areas. JSY is a safe motherhood intervention under the Mission launched on 12th April 2005. It is 100% centrally sponsored scheme and it integrates cash assistance with delivery and post-delivery care.
>
> (iii) Arranging private public partnerships (hereafter shall be referred as PPPs) with private health care institutions and doctors to provide such care against a fixed sum money in areas where public health services are lacking.
>
> (iv) provision of transport to the woman through either public or private transport and recompensating expenses to enable the woman to reach the hospital in time for adequate care.
>
> (v) allowing the Rogi Kalyan Samiti (hereafter shall be referred to as RKS) to charge user fees to raise funds in addition to the funds given by the government for maintaining the health institution and improving its services. R.K.S are the registered societies constituted in the hospitals as an innovative mechanism to involve the peoples representatives in the management of the hospital with a view to improve its functioning through levying user charges.

4. The Mission has been implemented in 18 high focus states, one of it being the State of Madhya Pradesh.

5. In Madhya Pradesh, the Mission as set out by the Ministry of Health and Family Welfare, Government of India has been adopted and a Programme Implementation Plan 2006-2012 has b/£en (sic) mooted out by the State Health Mission, Department of Health and Family Welfare, Government of Madhya, Pradesh with an object that all people living in the State of Madhya Pradesh will have the knowledge and skills required 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.

…

7. While implementing the mission it was noted that (i) Districts Chhatarpur, 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 following key elements:

(a) Access to emergency obstetric care

(b) Skilled attendant at birth

(c) Effective referral system

The strategy included: …

…

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 … 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 1,00,000 live births. It is urged that anemia 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, cornered 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 Misson (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…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. Nonholding 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…

…

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 reducing the MMR within the targeted period.

…

22. 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 [sic] 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.

23. We therefore, recommend following measure to be taken up in the earnest: At Sub-Centres and PHC Level and CHC/ District Level-

1. At Panchayat the 24 hours availability of trained woman as ASHA/Community Health Worker.

2. Two Auxiliary Nurse Mid-Wives at each Sub-Health Centre.

3. Three Staff-Nurses at the Primary Health Centre to ensure round the clock service therein.

4. Strengthen the Outpatient Services through posting/appointment of AYUSH doctors besides regular Medical Officers.

5. Uninterrupted Electricity -oply [*sic*] and the water supply to the Sub-Centres and Public Health Centres.

6. Ensure proper modern sanitation.

7. Ensure that, in all 227 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.

8. Ensure availability of vehicle round the clock under Janani Express Yojna.

9. Ensure that every pregnant women and new born is vaccinated with Tetanus, BCG, Polio, DPT etc.

10. 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.

12. To set up all 87 Rogi Kalyan Samitis.

13. Constitute Monitoring Committee at District and Block Level and ensure complete documentation of each and every patient.

14. 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 2006 - 2012, so that there can be an effective Control of the MMR.

25. 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 morbility [I*sic*] 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/I lakh 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.

26. 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.

27. The petition is thus, disposed of finally in above terms."

IN THE HIGH COURT OF SIKKIM

Rinzing Chewang Kazi v. State of Sikkim & Ors.
2016 SCC OnLine Sikk 38
Sunil Kumar Sinha, C.J. and Meenakshi Madan Rai, J.

This public interest litigation sought effective implementation of the National Rural Health Mission (NRHM) in the State of Sikkim and argued that the State's failure to provide adequate reproductive and child health services to women and children violates their rights under Articles 14, 15 and 21 of the Indian Constitution. The High Court issued directions for proper implementation of Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram under NRHM.

Sinha, C.J.: "By way of introduction, it may be stated here that this is a Public Interest Litigation seeking effective implementation of the National Rural Health Mission (for short NRHM) in the State of Sikkim by issuing appropriate orders to provide for required facilities and personnel in remote rural villages of the State, focusing in particular on the health of Women, Children and Senior Citizens being Marginalised Groups of society. It is also concerned with the violation of Articles 14, 15 and 21 of the Constitution alleging failure on the part of the Respondents to provide adequate facilities to women in terms of reproductive and child health services.

2. …The objective of the NRHM, *inter alia*, is to reduce maternal mortality rate, infant mortality rate and total fertility rate. Within the ambit of the NRHM is the Janani Suraksha Yojana (JSY), a scheme, which is a 100% Centrally Sponsored and "*…..integrates the cash assistance with antenatal care during the pregnancy period, institutional care during delivery and immediate post partum period in a health centre by establishing a system of coordinated care by field level health workers.*" (See Janani Suraksha Yojana Guidelines for Implementation, Ministry of Health and Family Welfare, Government of India)." The vision of the scheme besides being to reduce maternal mortality and the infant mortality rate, seeks to increase institutional deliveries in women belonging to the Below Poverty Line (BPL) households of the age of 19 years or above, up to two live births. Along with the Scheme of Janani Suraksha Yojana, is the Janani-Shishu Suraksha Karyakram (JSSK) which assures that pregnant women and newborns do not have to incur pocket expenses in all Government institutions and lays down the entitlements for pregnant women and sick new born till 30 days of the birth.

3. Under the NRHM, Accredited Social Health Activists (ASHA) are to be appointed in each village and trained to act as an interface between the community and the public health systems. They are to assist the pregnant women belonging to households Below Poverty Line (BPL) in obtaining the use of health services by inter alia undertaking certain responsibilities, which include identifying pregnant women, providing them with checkups, counseling them for institutional deliveries, etc.

4. This Writ Petition, as already stated has been filed seeking proper implementation of the NRHM.

5. In view of the facts put forth in the Writ Petition, this Court vide an Order on 24.8.2012, observed as follows:-

> "…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 level. 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 names/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 2(two) weeks, if not already available…"

…

16. A "Brief Fact Finding Report of the Ground" (sic) was filed by the Petitioner. In terms of the said Report, this Court vide its Order dated 23.9.2013, observed that the Petitioner has *inter alia* pointed out the condition of Gynaecology Department, STNM Hospital at Gangtok, where the patients were facing great hardship on account of dearth of sufficient number of toilets. Admitting this in substance, the State Respondents undertook to explore possibilities to build new

toilets for the OPD patients and attendants accompanying the ailing. The Court directed the State Respondents to expedite the construction of at least one more toilet on each of the floors of the building where Gynaecology Wards were situated, with a further direction that a report be submitted within 30 days regarding the progress…

…

22. On 7.8.2014, a second "Fact finding Report" was filed by the Petitioner, which dealt with a fact finding conducted by Advocate, Sarita Bhusal and one Maya Sikan (Health Right Activist from Delhi) on 20-21 May, 2014 concerning the implementation of the NRHM on the ground in the State, wherein it was alleged that most pregnant and lactating women were made to purchase basic medicines like Iron, Folic Acid, Calcium Pills and necessities, such as cotton, gloves, etc. That, basic instruments like ECGs were not available either in the Primary Health Centres of District Hospitals. Pregnant women were made to sleep in the corridors near the toilet, new born babies were kept in rooms without proper ventilation. No incubator facilities were available for new born children, neither was there an Operation Theatre in the District Hospital at Mangan, while both Hospitals at Mangan and Singtam had no Blood Banks and that there was lack of proper sanitation and toilet facilities in Primary Health Centres, hence the NRHM Scheme is not being implemented as envisaged.

…

25. It is thus clear that this Court had issued various directions in public interest on different dates and had monitored [*sic*] and compliance reports were filed by the State.

26. Now, we would like to concentrate on the core issues highlighted by the Petitioner in CMA No. 387/2014 and CMA No. 251/2015.

27. Dr. Doma T. Bhutia, learned Counsel appearing on behalf of the Petitioner, has firstly contended that Maternal Death Reviews (MDRs), as per the Government of India Guidance Manual on maternal death, are not being regularly done and the reviews are not being published in the website of the National Health Mission (NHM) of Sikkim, therefore, immediate directions should be issued…

28. Having heard Counsel for both the parties, we are of the view that there is no harm if the above materials are uploaded in the website. On the contrary, they would be helpful for awareness as also leading to transparency and would further show the real picture at a glance for self evaluation. The Maternal Death Reviews and Community based monitoring should be done regularly in the larger public interest and necessary materials should be uploaded in the website of the NHM and we direct accordingly.

29. Dr. Bhutia then contended that the State be directed to create blood banks and blood storage facilities as also arrange sufficient number of oxygen cylinders in every district to prevent maternal deaths related to bleedings...The State has a long term goal to update all 4 district hospitals to Indian Public Health Standards (IPHS). However, it requires that these institutions have to first function as First Referral Units (FRUs) with a minimum provision of facilities for Emergency Obstetric Care including surgical interventions like Caesarean Sections, New-born Care and Emergency Care of sick children and blood storage facility… [E]ven according to the NRHM, blood storage facility should be there in a CHC. Apart from the above, if we look into the services guaranteed for the health care, it is a matter of common knowledge that blood transfusion would be necessary in many health services proposed. Thus, taking guidelines from the NRHM, we are of the view that there should be a blood bank in every district hospital and there should also be blood storage facility at least in CHCs. We are conscious that we are not experts, however, the view which we have taken, is based upon the documents of NRHM as also the comprehensive report issued by the State Government. We, therefore, direct that the State Government shall make all endeavour to establish a blood bank in each district and also to establish blood storage facility in each CHC in near future.

30. Dr. Bhutia has also contended that enough number of oxygen cylinders should be available in the hospitals. She quoted example that many times only one cylinder caters the need of entire ward where number of patients/new-born children are very high. We have no data about the number of oxygen cylinders usually deployed in different hospitals. Mr. Pradhan has contended that sufficient number of oxygen cylinders have been put in all the district hospitals, which we also find in reply to CMA No. 387/2014. We trust that there would not be any crisis in this regard and the things would go smoothly.

31. Dr. Bhutia then contended that the State should initiate a free emergency transport system for referrals in compliance with Janani Sishu Surakshya Karyakram (JSSK). Mr. Pradhan has contended that JSSK was started since the year 2011 and under the JSSK, free transport, free drugs and diet for pregnant mothers and infants are provided. The IPHS

guidelines would show that JSSK was an initiative to assure free services to all pregnant women and sick neonates accessing public health institutions. The scheme envisages free and cashless services to pregnant women including normal deliveries and caesarean section operations and also treatment of sick new-born (up to 30 days after birth) in all Government health institutions across the States. This initiative supplements the cash assistance given to pregnant women under the Janani Surakshya Yojana (JSY) and is aimed at mitigating the burden of out of pocket expenditure incurred by pregnant women and sick newborns. (see p.9 of the IPHS guidelines). Under various entitlements for pregnant women, one is free transport from home to health institutions, between facilities in case of referrals and drop back from institutions to home. The State has filed two quarterly status reports regarding implementation of JSSK (April to June, 2014 and July to September, 2014)…It is thus clear that the State has already initiated free emergency transport system for referrals under the JSSK and no directions are required to be issued in this regard.

32. Dr. Bhutia next contended that a Committee should be constituted to investigate, report and find out solutions for poor implementation of JSY. We find that there is no pleading in the Writ Petition making ground for constitution of such a Committee and direct investigation, as prayed for. Even, the Petitioner has never sought any relief in this regard. It appears that while the Counsel for the Petitioner expressed to sort out remaining core issues after various interim directions, the said point was taken up in CMA No. 387/2014 and a direction was sought.

33. …We have scrutinized various documents filed along with the Writ Petition and we do not find that the Petitioner even has made a foundation to show that there was poor implementation of JSY…

34. It is, therefore, clear that there are no sufficient reasons before us to constitute a Committee for the above purposes and to take a view that there is poor implementation of JSY and a Committee is immediately required to be constituted to investigate all these…

35. Dr. Bhutia then contended that all vacant posts of Doctors and Staff Nurses be directed to be filled up immediately… It is, thus, clear that the Government has already taken steps to fill up the existing vacancies in the above manner when it was being monitored by this Court. Dr. Bhutia has also argued that Doctors and Nurses posted in rural areas should be given incentives. About the incentives of the Doctors and Nurses posted in the rural areas, statement has been made in CMA No. 387/2014 that the Doctors and Nurses appointed under NHM posted in difficult areas are paid higher remuneration as compared to the others. As such, no further directions are required in these matters.

36. Dr. Bhutia then contended that directions may be issued for improved hygiene, increased staff and increased bed capacity in STNM Hospital, Gangtok. It was brought to our notice that additional room with 10 beds was established for post natal care mother at the ground floor of Gynae building and ill-hygienic conditions which were on account of over-crowding have now improved. It was also brought to our notice that Department is creating 10 bedded post natal ward within 2-3 months by shifting School Health and National Blindness Control Programme Room situated at ground floor of Gynae complex. This will further improve the ill-hygienic situation. Additional toilet has also been constructed near Gynae complex. Additional two staff nurses from NHM have also been deployed. Besides the above, vide Affidavit dated 30.05.2015, it was stated by the Additional Secretary that construction of a Multi Specialty Hospital at Sichey, Gangtok is under progress and its bed strength was revised from 575 to 1000…

37. Dr. Bhutia also contended that a direction should be issued to the State-Respondents to have emergency helpline numbers and emergency Doctors' cell numbers in all the four districts to address health related issues in distress/ emergency situation. In reply to the above issue, it was submitted by Additional Advocate General that emergency helpline numbers are already there ... In reply to the above issue, it was submitted by Additional Advocate General that emergency helpline numbers are already there.

38. Therefore, nothing is required to be done on the said aspect.

…

41. After conclusion of the arguments, on the last date, learned Additional Advocate General made some suggestions to be implemented immediately. They are (i) free medicine counter in all district hospitals/STNM; (ii) all free medicines as per the list provided to this Court to be made available in the said counter; (iii) separate OPD card centre at STNM Hospital, Gangtok viz. male, female and senior citizens; (iv) Out Patient Duty (OPD) morning and afternoon at STNM Hospital should be regular. Afternoon OPD should be maintained strictly and (v) an inquiry desk to be made available at STNM Hospital which should be easily visible to assist the patients/parties. PIL is not in the nature of adversary litigation but it is a challenge and an opportunity to the Government and its officers to make basic human rights meaningful to the deprived and vulnerable sections of the community and to assure them social and economic justice (vide *Bandhua*

Mukto Morcha v. *Union of India*, (1984) 3 SCC 161 : AIR 1984 SC 802). Therefore, any good suggestions coming from either side can be taken up for consideration and if it appears to be permissible under the law, the same may be directed to be implemented. We are of the view that the above suggestions coming from the Additional Advocate General can be accepted for implementation and we do it accordingly.

42. On the discussions made above, we dispose of this PIL along with CMA Nos. 387/2014 & 251/2015 on following terms:-

(1) The State will ensure availability of life saving drugs in all the hospitals/health centres. Interim direction in this regard vide Order dated 24.08.2012 is made absolute.

(see Order dated 24.08.2012)

(2) Other interim directions on which compliance reports have not been filed shall also be taken as absolute.

(3) JSY and JSSK shall be implemented in their letter and spirit so that the eligible women and children derive proper benefits from these schemes.

(4) The Maternal Death Reviews and Community Based Monitoring shall be done regularly and necessary materials shall be uploaded in the website of the NHM.

(see paragraph 28)

(5) The State Government shall make all endeavour to establish a Blood Bank in each district and also to establish Blood Storage facility in each CHC in near future. (see paragraph 29)

(6) State will create a free medicine counter in all district hospitals.

(see paragraph 39)

(7) All free medicines, as per the list provided to this Court, shall be made available in the said counters. (see para 39)

(8) There shall be separate OPD card centres at STNM Hospital, Gangtok viz. male, female and senior citizens. The Out Patient Duty (OPD) morning and afternoon at STNM Hospital shall be regular and afternoon OPD should be maintained strictly.

(see paragraph 39)

(9) An inquiry desk shall be made available at STNM Hospital, Gangtok, which would be easily visible to assist the patients/their attendants.

(see paragraph 39)

43. In the facts and circumstances of the case, there shall be no order as to costs."

IN THE HIGH COURT OF CHHATTISGARH

Kali Bai v. Union of India & Ors.
2017 SCC OnLine Chh 1081
Thottathil B. Radhakrishnan, C.J. and Sharad Kumar Gupta, J.

A public interest litigation was instituted by a woman whose daughter died due to the poor health facilities and mismanagement at the Community Health Centre (CHC), Gaurela where she was admitted for delivery. Arguing that deficiencies in medical facilities at the CHC violated the right to reproductive health arising from Article 21 of the Indian Constitution and India's international obligations, the petitioner sought directions for improvement of public health facilities and corrective measures for management of maternal mortality.

Radhakrishnan, C.J.: "This writ petition is instituted as a Public Interest Litigation by a woman of Gaurela Block in District Bilaspur, who allegedly lost her daughter due to the poor health facilities and mismanagement of the situations that followed her admission to the Community Health Centre, Gaurela; for short, "CHC", for delivery. The Petitioner does not seek any order personally in her favour…

2. Petitioner pleads that World Health Organisation has defined "maternal death" as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes." She points out that the Ministry of Health and Family Welfare in the Government of India had reported Chhattisgarh Maternal Mortality Ratio; for short, "MMR", at a very high level and Bilaspur district as having one of the highest MMRs in the State and in India. In public interest, the Petitioner seeks a direction to the Respondents to fill the post of Anesthetist and Gynecologist trained in Emergency Obstetric Care in the CHC and to establish a blood storage facility in that CHC. She also seeks a direction to provide Sonography diagnostic facilities and to ensure that Caesarean section deliveries are conducted in the CHC. She seeks a further direction for supply of free medicine in the CHC and to ensure that corrective measures be taken in the sector of management of maternal mortality. She also seeks a direction that the findings of maternal death audits and the corrective measures in the maternal deaths which occurred in the year 2013 - 2014 be uploaded on the website.

…

5. Making reference to the decisions of the Hon'ble Supreme Court of India in *Pt. Parmanand Katara* v. *Union of India*; 1989 SCR (3) 997, *Consumer Education & Research Centre* v. *Union of India*; (1995) 3 SCC 42, *Paschim Banga Khet Mazdoor Samity* v. *State of W.B.*; (1996) 4 SCC 37 as well as the decision of Delhi High Court in *Laxmi Mandal* v. *Deen Dayal Harinagar Hospital*; in Writ Petition (C) No. 8853 of 2008, decided on 04.06.2010, and that of the Madhya Paradesh High Court in *Sandesh Bansal* v. *Union of India*; in Writ Petition No. 9061 of 2008, decided on 06.02.2012, learned counsel for the Petitioner highlighted the scope of Article 21 of the Constitution in relation to the facts and situations pleaded by the Petitioner. Making reference to the provisions of the Universal Declaration of Human Rights; for short 'UDHR' and the Convention on the Elimination of all Forms of Discrimination Against Women; for short 'CEDAW'; she argued that the demonstrated shortage of the medical facilities in the Gaurela CHC results in violation of the human rights.

…

7. Right to health includes the right to access public health facilities and right to minimum standard of treatment and care through such facilities. Such right to health and reproductive rights of the mother are two among the inalienable components of basic, fundamental and human right to life under Article 21 of the Constitution. Identification of high risk pregnancies, followed by appropriate and prompt referral of cases needing specialist care are indefeasible components of access to protection and enforcement of reproductive rights of the mother and eligibility to medical care and support to ensure protection of the foetus from being lost.

8. India is either a State party or a ratifying State as regards different International Declarations and Conventions. The State has the international obligation and constitutional responsibility to give effect to, and honour, the terms of such Declarations and Conventions. Motherhood is entitled to special care and assistance in terms of the UDHR. International Covenant on Economic, Social and Cultural Rights, *inter alia*, envisages provisions to ensure reduction of the stillbirth rate and of infant mortality and the obligation of governance to ensure the right of everyone to enjoyment of highest attainable standard of physical and mental health. These are provisions among those international obligations which are binding on India by reason of their acceptance and ratification. Similar are the provisions of the CEDAW, which enjoins, in particular, that women shall be ensured appropriate services in connection with pregnancy, confinement and post-natal period. CEDAW also contains the obligation to ensure focusing on women in rural areas and the obligation to ensure adequate health care facilities. It is the obligation of the State to diminish infant and child mortality and to ensure appropriate pre-natal and post-natal health care for mothers. These situational legal aspects have to be fruitfully effectuated to necessarily ensure that the steps said to have been taken by the Respondents are appropriately carried forward to augment the facilities in the CHCs and other health facility providing centres.

9. Article 42 of the Constitution, among the Directive Principles of State Policy enjoins, among other things, that the State shall make provision for maternity relief. The provisions contemplated in that Article are not confined to social security measures in connection with work and employment or places of work and employment. The gaze of that Article should guide the State in carrying forward the relevant provisions made by it in consonance with the eligibility of women to enjoy their right to life in terms of Article 21 of the Constitution. This is so because the Constitutional dictate [*sic*] to the establishment of governance of a Welfare State is to secure the welfare of the people. Providing adequate medical facilities for the people is an inexcusable component of the obligation of governance of a welfare State. Such obligation is discharged by the Governments by running hospitals and health centres which provide medical care.

10. The fundamental right to life guaranteed by Article 21 of the Constitution imposes corollary obligation on the State to safeguard the right to life of every person. The Government hospitals including the CHCs run by the State ought to be institutions which extend medical assistance for preserving human life because preservation of human life is of seminal and paramount importance in the context of right to life guaranteed under Article 21 of the Constitution. Failure on the part of Government hospitals to provide timely medical treatment to a person in need of such treatment results in violation of right to life of that person guaranteed under that Article. The State's obligation with reference to Article 21 is to be discharged by ensuring the availability of the Doctors with due acumen at the Government hospitals and by providing equipments of required standard and medicines, blood supplies and other requisites to ensure that the facilitation of the medical and health support through the different hospitals including CHCs are carried out in satisfaction of the constitutional prescriptions and legitimate goals of the polity as a whole.

11. Relevant policy documents, materials and the programmes of the Government of India shows that the National Rural Health Mission was launched, *inter alia*, to reduce MMR. Access to emergency obstetric care was identified as one of the key elements in the Programme Implementation Plan. Improvement of access to skilled delivery care and emergency obstetric care were seen necessary. Reduction of maternal morbidity and mortality due to post-partum haemorrhage by active management of the third stage of labour is also an inexcusable need. The infrastructure had to be strengthened by ensuring that operation theaters, labour rooms and maternity wards are updated to suit the requirements in Comprehensive Emergency Obstetric Neonatal Care and Basic Emergency Obstetric Neonatal Care facilities. Providing adequate facilities to ensure all services including blood transfusion and storage facilities are also needed to effectuate proper implementation of the goals sought to be achieved by such programmes. There is no gainsaying in the second decade of the 21st century that provisions for such facilities can wait or would take its own time.

12. Gaurela is a part of the State of Chhattisgarh which has a large tribal population. Making reference to the census of 2001, it was noted by the National Legal Services Authority; for short 'NALSA', that majority of the population of "Particularly Vulnerable Tribal Groups" population lives in seven States including the State of Chhattisgarh. They need special attention due to their vulnerability. Those who do not fall into that category, be they in groups identified as Scheduled Tribes or otherwise also fall into the basket which carries the homogeneous group of people of this part of Nation. Section 4(d) of the Legal Services Authorities Act, 1987 enjoins that the Central Authority shall take necessary steps by way of social justice litigation with regard to, *inter alia*, consumer protection as well as any other matter of special concern to the weaker sections of the society…While NALSA formulated a scheme aimed at ensuring access to justice to the tribal population in the country and made NALSA (Protection and Enforcement of Tribal Rights) Scheme, 2015, it had identified health issues as among different challenges to that community. By and large, that is a challenge which would extend to all communities having regard to the geographical settings and the socio-economic situations in different areas. NALSA specifically noted that though buildings are built and health care institutions created in the form of health sub-centres, PHCs and CHCs, they often remain dysfunctional and that this situation is further compounded by inadequate monitoring, poor quality of reporting and accountability. It was also noted that the health care needs as well as difficulties in delivering health care in a geographically scattered, culturally different population surrounded by forests and other natural forces require issue specific look and are to be pointedly addressed notwithstanding the national health model which is primarily designed for the non-tribal areas. NALSA also noticed that factors such as unfriendly behaviour of the staff, language barrier, large distances, poor transport, low literacy and low health care seeking, lead to lower utilization of the existing health care institutions in tribal areas. We notice these factors at this juncture since the said NALSA Regulations makes it obligatory on the State Legal Services Authority; for short 'SLSA', to provide, among other things, legal assistance, if needed, by initiating Social Justice Litigation with the approval of the Executive Chairman of the SLSA concerned, whenever required. The said Scheme further provides that the Legal Services Authorities could play a vital role in providing medical help by, essentially, playing a connecting role as between the needy and the medical and health service. These provisions clearly show that the SLSA and the District Legal Services Authority; for short, 'DLSA', concerned ought to be well informed with the availability of the facilities, or the lack of them, in any governmental medical institution which is meant to provide service in such sectors. Therefore, it will be open to the SLSA or the DLSA to obtain reports regarding the provisions for health care, including as regards the deficits brought by the Petitioner to the notice of this Court for consideration, with the plea for issuance of requisite directions.

13. In the result, the writ petition is ordered directing that:

(i) The Respondents shall, without fail, ensure that the CHC at Gaurela and the different institutions which are referred to in the return dated 20.06.2017 filed on behalf of the Respondents, in relation to the medical facilities of the area concerned, shall be effectuated completely and meaningfully, in terms of facilities, personnel and equipments, medicines and blood storage facility, within a period of three months from today. It shall be further ensured that such facilities are run without any deficit in terms of Doctors, Nursing Staff, Paramedical Staff and other personnel as are required and by ensuring uninterrupted supply of requisite medicines, support equipments, blood and other necessities. The Respondents shall specifically address the requirement of Anesthetist, Gynecologist trained in emergency Obstetric care and the need to establish blood storage facility, Sonography diagnostic facility as well as free supply of medicines in the Gaurela CHC.

(ii) The Respondents 3 and 4 are directed to provide bi-monthly report to the DLSA, Bilaspur regarding all the affairs of CHC Gaurela as may be relevant in the context of facts and factors dealt with in this judgment and the directions issued herein. The Member Secretary, DLSA, Bilaspur, is directed to visit CHC Gaurela and other medical institutions of that area once in three months or at any time, including at such shorter intervals as may be found necessary by the Chairperson of that DLSA. The Chhattisgarh SLSA is directed to ensure that it takes due action on the reports of the Bilaspur DLSA from time to time on issues relating to those medical facility centers.

(iii) The 3rd Respondent is further directed to provide an Action Taken Report on the compliance of the directions contained in this judgment to the Chairperson, DLSA, Bilaspur, on or before 30th December, 2017 ensuring that such details given therein are true and correct, issue specific. Such report shall bind all the Respondents.

(iv) Security amount, if any, deposited by the Petitioner be refunded."

Endnotes

1 World Health Organization, Maternal Health, *accessed at* http://www.who.int/topics/maternal_health/en/.

2 The Supreme Court has recognized the right to health as a facet of the right to life under Article 21 in cases such as Pt. Parmanand Katara v. Union of India, (1989) 4 SCC 286 and Paschim Banga Khet Majoor Samity v. State of West Bengal, (1996) 4 SCC 37. *See infra* the extension of this right to cover right to reproductive and maternal health.

3 Kali Bai v. Union of India, 2017 SCC OnLine Chh 1081.

4 Examples include Centre for Health and Resource Management v. Union of India, 2015 SCC OnLine Pat 1243 and Dunabai v. State of M.P., 2011 SCC OnLine MP 1360. In State of U.P. v. Snehalata Singh @ Salenta, SLP (C) No. 9299/2018, the Supreme Court stayed the operation of directions issued by the Allahabad High Court in Snehalata Singh @ Salenta v. State of U.P., PIL No. 14588/2009 dated Mar. 9, 2018. There have been no substantive orders in this case by the Supreme Court and the matter is pending before the Court.

5 (2010) 172 DLT 9.

6 For example, the Janani Suraksha Yojana (JSY), Integrated Child Development Scheme (ICDS), National Maternity Benefit Scheme (NMBS), Antyodaya Anna Yojana (AAY) and National Family Benefit Scheme (NFBS).

7 W.P. No. 9061 of 2008 (Order dated Feb. 6, 2012) (High Court of Madhya Pradesh).

8 2016 SCC OnLine Sikk 38.

9 (2009) 16 SCC 149.

10 In People's Union of Civil Liberties v. Union of India, (2010) 13 SCC 63, the Supreme Court issued notice on an application filed by the Union of India seeking to restrict maternity benefits under the NMBS and Janani Suraksha Yojana on the basis of the number of children and the age of the woman seeking such benefits.

11 2011 SCC OnLine Del 137.

12 2017 SCC OnLine Chh 1081.

13 U.N. Office of the High Commissioner for Human Rights, "Status of Ratification Interactive Dashboard—India," http://indicators.ohchr.org/.

14 D*raft Articles on Responsibility of States for Internationally Wrongful Acts, adopted by the Commission at its fifty-third session in 2001 (Final Outcome) (International Law Commission [ILC]), contained i*n U.N. Doc. A/56/49(Vol. I)/Corr.4 (2001)*, Arts. 3-4.*

15 Vishaka v. State of Rajasthan, AIR 1997 SC 3011.