IN THE HIGH COURT OF DELHI AT NEW DELHI

W.P.(C) 8853/2008

LAXMI MANDAL ..... Petitioner
Through: Mr. Colin Gonsalves, Sr. Advocate with Mr. Divya Jyoti Jaipuriar and Mr. Tariq Adeeb, Advocates

versus

DEEN DAYAL HARINAGAR HOSPITAL
& ORS. ..... Respondents
Through: Mr. A.S. Chandhiok, ASG with Mr. Baldev Malik and Mr. Harsh Surana, Advocates for R-2 & 4
Mr. Anuj Aggarwal with Mr. Mridul Chakravarty, Advocates for R-3
Mr. Manjit Singh with Mr. Yashpal Rangi, Advocates for R-6 to 8
Ms. Zubeda Begum with Ms. Sana Ansari, Advocates for GNCTD along with Dr. S. Brinda (DFW), Dr. Kirti Bhushan, OSD, Dr. Ashok Kumar, MSMH, DHS, Dr. Monica Rana, SPV(DSHM) and Mr. Nutan Mundeja, SPO (DSHM) from Health Deptt.
Mr. R.N. Mangla Addl. Director, DWCD with Mrs.Savita, Dy. Director, Mrs. Deepti Jain CDPO, Nizamuddin and Mrs. Gurmeet, Supervisor, Nizamuddin.
Ms. Sonia Mathur with Mr. Sumit Kumar Singh, Mr. Sushil Kumar Dubey and Mr. Rajat Soni along with Mr. Subhash Chander, Asstt. Comm. F&S Deptt.

W.P.(C) 10700/2009

JAITUN ..... Petitioner
Through: Mr. Colin Gonsalves, Sr. Advocate with Mr. Divya Jyoti Jaipuriar and Mr. Tariq Adeeb, Advocates

versus

MATERNITY HOME MCD , JANGPURA & ORS. .... Respondents
Through: Mr. A.S. Chandhiok, ASG with Mr. Baldev Malik and Mr. Harsh Surana, Advocates for UOI
Ms. Zubeda Begum with Ms. Sana Ansari, Advocates for R-3 & 6 along with Dr. S. Brinda

(DFW), Dr. Kirti Bhushan, OSD, Dr. Ashok Kumar, MSMH, DHS, Dr. Monica Rana, SPV (DSHM) and Mr. Nutan Mundeja, SPO (DSHM) from Health Deptt.
Mr. R.N. Mangla Addl. Director, DWCD with Mrs.Savita, Dy. Director, Mrs. Deepti Jain CDPO, Nizamuddin and Mrs. Gurmeet, Supervisor, Nizamuddin.
Ms. Maninder Acharya with Mr. Apurva Kothari, Advocates for MCD

CORAM: JUSTICE S.MURALIDHAR

1. Whether reporters of local paper may be allowed to see the order? Yes

2. To be referred to the reporter or not? Yes

3. Whether the order should be referred in the digest? Yes

JUDGMENT
04.06.2010

Introduction

1. These two petitions highlight the deficiencies in the implementation of a cluster of schemes, funded by the Government of India, which are meant to reduce infant and maternal mortality. The issues common to both petitions concern the systemic failure resulting in denial of benefits to two mothers below the poverty line (BPL) 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

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 center 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.

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

The NMBS

9. The National Maternity Benefit Scheme (`NMBS') basically talks of providing cash assistance of Rs.500 to pregnant women. In order to clear the confusion that the cash assistance under the NMBS is independent of the cash assistance under the JSY, the Supreme Court on 20th November 2007 passed an order in the ***PUCL Case*** directing that all the State governments and Union Territories (UTs) shall continue to implement the NMBS and ensure that "all BPL pregnant women get cash assistance 8-12 weeks prior to the delivery." It was

specifically directed that "the amount shall be Rs. 500/- per birth **irrespective of number of children and the age of the woman**." It was reiterated that "It shall be the duty of all the concerned to ensure that the benefits of the scheme reach the intended beneficiaries. In case it is noticed that there is any diversion of the funds allocated for the scheme, such stringent action as is called for shall be taken against the erring officials responsible for diversion of the funds."

10. At this juncture it must be noted that in para 15 of its order dated 20th November 2007, the Supreme Court observed as under:

> "15. At this juncture it would be necessary to take note of certain connected issues which have relevance, it seems from the scheme that irrespective of number of children, the beneficiaries are given the benefit. This in a way goes against the concept of family planning which is intended to curb the population growth. Further the age of the mother is a relevant factor because women below a particular age are prohibited from legally getting married. The Union of India shall consider this aspect while considering the desirability of the continuation of the scheme in the present form. After considering the aforesaid aspects and if need be, necessary amendments may be made."

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

the field and is required to be strictly implemented by all the States and UTs.

The ICDS

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.

13. The package of services provided under the ICDS include:

1. supplementary nutrition,
2. immunization,
3. health check-up,
4. referral services,
5. pre-school non-formal education and
6. nutrition & health education.

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;
(2) widows and other single women with no regular support;
(3) old persons (aged 60 or above) with no regular support and no assured means of subsistence;
(4) households with a disabled adult and assured means of subsistence;
(5) households where due to old age, lack of physical or mental fitness, social customs, need to care for a disabled, or other reasons, no adult member is available to engage in gainful employment outside the house;
(6) primitive tribes"

17. In its order dated 17th November 2004, the Supreme Court noted that the AAY was "meant for the poorest of the poor." It went on to observe that:

> "A person entitled to the benefit under this scheme is issued a red card. The holder of red card entitles him/her to obtain grain and rice from the dealer of Public Distributor System (PDS) at a highly subsidised rate which at present is rupees two per kilogram for wheat and rupees three per kilogram for rice.
>
> First of all it is of utmost importance that those who have already been issued red card shall straightway be supplied the rice and grain as per their entitlement. It is also important that those falling under this category should be immediately identified. The special attention is required to be given to Primitive Tribal Groups, which we are told, are in large in Maharashtra, West Bengal, Jharkhand and Madhya Pradesh, which are still be to identified in large numbers, card issued and grains supplied. We direct all the State Governments to

complete the process of identification of persons falling under this scheme and issue them the red card by the end of the year so that immediately thereafter supply of food grains to them may commence."

The NRHM

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 counseling to adopt appropriate Family planning methods,
- Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions (Wherever the ANM is trained on IUD insertion)
- 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.

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

The Constitutional right to health and reproductive rights

19. A conspectus of the above orders would show that the Supreme Court has time and again emphasised the importance of the effective implementation of the above schemes meant for the poor. They underscore the interrelatedness of the 'right to food' which is what the main ***PUCL Case*** was about, and the right to reproductive health of the mother and the right to health of the infant child. There could not be a better illustration of the indivisibility of basic human rights as enshrined in the Constitution of India. Particularly in the context of a welfare State, where the central focus of these centrally sponsored schemes is the economically and socially disadvantaged sections of society, the above orders of the Supreme Court have to be understood as preserving, protecting and enforcing the different facets of the right to life under Article 21 of the Constitution. As already noted, these

petitions focus on two inalienable survival rights that form part of the right to life. One is the right to health, which would include the right to access government (public) health facilities and receive a minimum standard of treatment and care. In particular this would include the enforcement of the reproductive rights of the mother and the right to nutrition and medical care of the newly born child and continuously thereafter till the age of about six years. The other facet is the right to food which is seen as integral to the right to life and right to health.

20. The right to health forming an inalienable component of the right to life under Article 21 of the Constitution has been settled in two important decisions of the Supreme Court: ***Pt. Parmanand Katara v. Union of India (1989) 4 SCC 286*** and ***Paschim Banga Khet Majoor Samiti v. State of West Bengal (1996) 4 SCC 37***. The orders in the ***PUCL Case*** are a continuation of the efforts of the Supreme Court at protecting and enforcing the right to health of the mother and the child and underscoring the interrelatedness of those rights with the right to food. This is consistent with the international human rights law which is briefly discussed hereafter.

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

> **Article 25**
> (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

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

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

Article 10

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

2. Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.

3. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. 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.

23. The Committee on Economic Social and Cultural Rights has in its General Comment No. 14 of 2000 on the right to health under the ICESCR explained the scope of the rights as under:

> "8. The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health. ...
>
> 11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels. ...
>
> 14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a)) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."

24. The reproductive rights of women have been accorded recognition, and the obligations of States have been spelt out in the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) which is another international convention ratified by India. The relevant provisions of the CEDAW in this context are:

> **Article 12**
>
> 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
>
> 2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.
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> **Article 14**
>
> 1. States Parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.
>
> 2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:
>
> > (a) To participate in the elaboration and implementation of development planning at all levels;
> >
> > (b) To have access to adequate health care facilities, including information, counselling and services in family planning;
> >
> > (c) To benefit directly from social security programmes;
> >
> > (d) To obtain all types of training and education, formal and non-formal, including that relating to functional literacy, as well as, inter alia, the benefit of all community and extension services, in order to increase their technical proficiency;

(e) To organize self-help groups and co-operatives in order to obtain equal access to economic opportunities through employment or self employment;

(f) To participate in all community activities;

(g) To have access to agricultural credit and loans, marketing facilities, appropriate technology and equal treatment in land and agrarian reform as well as in land resettlement schemes;

(h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.

25. The Child Rights Convention (CRC) which has also been ratified by India delineates the rights of the newly born and the young child thus:

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and

nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 27

1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.

3. States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.

4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.

26. International human rights norms as contained in the Conventions which have been ratified by India are binding on India to the extent they are not inconsistent with the domestic law norms. The Protection of Human Rights

Act, 1993 (PHRA) recognises that the above Conventions are now part of the Indian human rights law. Section 2(d) PHRA defines "human rights" to mean "the rights relating to life, liberty, equality and dignity of the individual guaranteed by the Constitution or embodied in the International Covenants and enforceable by courts in India" and under Section 2(f) PHRA "International Covenants" means "the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights adopted by the General Assembly of the United Nations on the 16th December, 1966."

27. The orders in the ***PUCL Case*** implicitly recognize and enforce the fundamental right to life under Article 21 of the Constitution of the child and the mother. This includes the right to health, reproductive health and the right to food. In effect, the Supreme Court has spelt out what the "minimum core" of the right to health and food is, and also spelt out, consistent with international human rights law, the "obligations of conduct" and the "obligations of result" of the Union of India, the States and the UTs. While recognizing the indivisibility of civil rights and social and economic rights, the Supreme Court has made them enforceable in courts of law by using the device of a "continuing mandamus." On their part, the High Courts in this country would be obligated to carry forth the mandate of the orders of the Supreme Court to ensure the implementation of those orders within the States and UTs. This then forms the background to this Court's intervention in these petitions.

Facts of the two Cases:

Shanti Devi and her daughter Archana

28.1 The facts stated in W.P.(C) No. 8853 of 2008 show that Shanti Devi was born in a poor family in Bihar. She was married to Kishan Mandal. Shanti Devi and her family shifted to Faridabad for better means of employment for her husband. Shanti Devi, at this point, had two children, however, she had had four pregnancies, wherein two resulted in the death of the foetus or the child. Generally, Shanti Devi was of poor health and suffered from anemia and tuberculosis.

28.2 When Shanti Devi was in the 7th month of her fifth pregnancy, she was suffering from severe oedema, severe anemia and fever. She had also suffered from a fall on the stairs of the building where she was residing. She saw a *Dai* (midwife) as she could not afford to see a doctor. The *Dai* advised that she should be taken to Faridabad Hospital. She could only be taken to the hospital by her husband after a period of two weeks (or more), as she did not have the finances for the same. By this time, neither the *Dai* nor Shanti Devi could feel the baby moving inside her stomach.

28.3 She was brought to the Faridabad Hospital on 19th November 2008. Despite discovering that Shanti had miscarried the baby, the Faridabad Hospital did not give medicines for alleviation of pain or suffering to Shanti, instead she was referred to Sanjay Gandhi Hospital, New Delhi. The dead foetus was still in Shanti and she was severely aneamic at this point.

28.4 At Sanjay Gandhi Hospital, it was threatened that Shanti would not be treated if 4 bottles of blood were not provided to her immediately. After receiving blood, she was kept for 3 days, however, she was then advised to go to Saroj Hosptial, as Sanjay Gandhi Hospital did not have sufficient facilities – a bed in the Intensive Care Unit (ICU) for the removal of the foetus. On 22nd November 2008 Shanti Devi and her husband arrived at Saroj Hospital with a resident doctor of Sanjay Gandhi Hospital. The documents which proved that Shanti Devi was a BPL who needed urgent medical attention at no cost were provided. After the resident doctor left, Saroj Hospital refused treatment on the ground that she was not BPL and demanded 2.5-3 lakhs from Shanti Devi for the treatment. The Medical Superintendent at Sanjay Hospital did enquire with Saroj Hospital of the reasons for not admitting Shanti Devi.

28.5 After being denied treatment in Saroj Hospital, Shanti Devi was thereafter taken back to Sanjay Gandhi Hospital, from where she was referred to and treated at Deen Dayal Hospital. Here, it was diagnosed that she was suffering from lack of platelets derangement which occurs when women lack protein during pregnancy. The foetus was removed from her body.

28.6 On 12th December 2007 this writ petition was filed, praying for compensation, and for the State to abide by the National Rural Health Mission and the Janani Suraksha Yojana.

28.7 On 7th January 2009 this Court passed an order that Shanti Devi should be admitted and treated at Deen Dayal Hospital free of cost. The said order reads as under:

> "Ms. Sonia Mathur has produced original records of Deen Dayal Upadhyay Hospital, Hari Nagar, New Delhi. Mr. Ashok Aggarwal, learned counsel is present in Court. He submitted that pursuant to the directions of the Division Bench in "Social Jurist v. Govt. of NCT of Delhi" in Petition No. 2866/2002, he was appointed as Member of the Monitoring Committee for proper implementation of such policies. According to him, an offer was made to the petitioner's sister to have her admitted in the Saroj Hospital which was not accepted.
>
> After hearing counsel, the Court is of the opinion that the petitioner's sister should be immediately admitted to the Deen Dayal Hospital, Hari Nagar, New Delhi. Ms. Sonia Mathur assures that this would be done forthwith. Since there is no denial that the petitioner's sister is to be categorized as Below Poverty Line citizen, the respondent shall not charge any amount for treatment or diagnostic intervention or investigation.
>
> List on 27.02.2009.
>
> In the meanwhile, the respondent shall file affidavit enclosing the copies of relevant medical records.
>
> Order dasti to both the parties."

28.8 Shanti Devi became pregnant for the sixth time. On 28th January 2010 Shanti Devi died after giving birth to a pre-mature baby. She delivered at home without the presence of a skilled birth attendant. The daughter from Shanti Devi's sixth pregnancy, Archana was admitted at BK General Hospital at Faridabad in Haryana. However, it was feared that the BK General Hospital, Faridabad, could turn out Shanti Devi's daughter, as her

father did not have a BPL ration card issued in Haryana. The above facts were brought to the attention of this Court which passed the following order on 28th January 2010:

> "**CM Nos. 1238 & 1239 of 2010**
>
> 1. Notice. Ms. Sonia Mathur, learned counsel for the Respondents accepts notice. It is pointed out that Shanti Devi, the sister of the Petitioner, died immediately after giving the birth to a pre-mature baby girl on 20th January 2010. It is stated that the new born baby girl is currently being treated in B.K. General Hospital, Faridabad. It is stated that although the BK General Hospital is a hospital run by the Government of Haryana, there is every possibility of the said hospital turning out the baby girl since the child's father Krishan Mandal does not have a ration card issued in that State. In that event, the baby would not be able to receive emergency medical treatment. In the above circumstances, urgent directions are sought. Learned counsel for the Petitioner points out that what is immediately needed is the transportation of the child by an ambulance from the BK General Hospital to any government hospital in Delhi for ensuring her continued medical treatment.
>
> 2. Given the peculiar circumstances and the urgency of the matter, it is directed that the Respondent No.4 will forthwith arrange for transportation of the new born baby girl of late Smt. Shanti Devi in an emergency ambulance, which is properly equipped with an incubator (since the baby is stated to have been delivered premature), from the BK General Hospital at Faridabad to the neonatology/paedriatics wing of the Maulana Azad Medical College Hospital or any other appropriate government hospital in Delhi where she will continue to receive treatment till further orders from this Court. A doctor, specializing in neonatology should preferably accompany the ambulance. This should be done forthwith acting on the

certified copy of the present order which will be issued dasti under the signature of Court Master. Ms. Mathur will convey this order forthwith to Respondent No.4 for
immediate action. Additionally, the Registrar General of this Court will transmit this order by Fax/e mail forthwith to the Secretary (Health), GNCTD.
3. List on 1st February 2010."

28.9 Pursuant to the above order, Archana was shifted to Chacha Nehru Bal Chikitsalaya, Delhi. Thereafter she has been with her father and other relatives in Nangloi, New Delhi.

28.10. This Court on 8th March 2010 accepted the request of the petitioners that a maternal audit of the death of Shanti Devi be conducted by an expert, Dr. Prakasamma, who is Director, Academy for Nursing Studies and Women's Empowerment Research Studies, Hyderabad. Dr. Prakasamma has submitted a comprehensive report. The summary of the report is that:

(i) direct cause of Shanti Devi's death was the Extensive Hemorrhage (PPH) with Retained Placenta. However, there were many indirect and contributing factors to her death, which broadly include, her dismal socio-economic status which denied access to needed resources and services, and her poor health condition which is a culmination of anemia, tuberculosis and repeated, unsafe pregnancies.

(ii) Shanti Devi had severe anemia. Anemia is a major public health problem in India, as about half of the population of India is anemic. Women suffering from anemia have to face an additional burden when they become pregnant, because of the increased demand for nutrition. In India, anemia is responsible for 17% of maternal deaths, and the case fatality rate of pregnancy anemia approaches 6-17%.

(iii) Shanti Devi also suffered from Tuberculosis, even before she and her husband shifted to Faridabad (2005). There is scientific data which shows that tuberculosis definitely increases the risk of prematurity, small for the gestational age, neonatal morbidity and mortality. If Shanti's TB would have been prevented or treated in the beginning stages, Shanti would not have faced so many risks and ultimately died after her sixth delivery with retained placenta and haemorrhage. *"Like Shanti, there are several women with TB in the same building. There is a DOTS centre nearby. When we visited the centre and spoke to the ANM, Ms. Kaushalya, about the number of women who were on TB drugs, she said her records were not with her as she had left them at home. Discussion with ASHA (title for a person concerned and appointed for implementation of Janani Suraksha Yojana) who was also present in the subcentre revealed that Shanti Devi was not registered at the DOTS centre."*

(iv) Shanti fell from unprotected steps of her home during the seventh month of her fifth pregnancy. The fracture resulted in humerus (L), and multiple fracture ribs and could caused the death of foetus. The rib fractures could have further exacerbated the respiratory distress. She was taken to the hospital only two weeks after realizing that she did not have foetal movements.

(v) Shanti Devi was reported to be sick and thin and sat depressed all the time, especially, during the last pregnancy.

(vi) She faced poor living conditions, low access to food, information, resources, services which reduced her capacity to cope up with her physiological processes. Tuberculosis and anemia are the result of poverty and inadequate access to resources and services.

(vii) Shanti Devi's was born in Bihar which has been behind the rest of India in socio-economic and health indicators, more specifically, in this case, it has a high birth rate, highly

unfavourable ratio of women to men, low female literacy, higher incidence of death due to childbirth, higher percentage of anemic married women, etc.

(viii) Shanti Devi and her family shifted to Faridabad for better means of employment for her husband. Due to this migration, they did not have a ration card in Faridabad, despite repeated attempts to obtain the same. Consequently, they did not have access to subsidized food, education and health facilities, and could not avail of the entitlements of JSY.

(ix) Out of her six pregnancies, only 2 were institutional deliveries, and they were for evacuation of foetus. It is assumed that institutional deliveries are safe because they are conducted by skilled and qualified personnel. However, the functionality and responsiveness of the institutes is questionable. The attitude and prompt response of the providers is a major factor in whether the women use these facilities. In Bihar, less than a quarter of the deliveries take place in institutions.

(x) There are differing versions with what happened at Saroj Hospital. Malati, Lakshmi Mandal's wife said that when she spoke to the patients and attendants at the Hospital, while Shanti was being examined, she was told that *"no one got free treatment in this hospital and that it would cost lakhs!"* The hospital staff asked her to keep half a lakh rupees ready. According to her, the hospital reception asked them to either pay the money or produce a BPL card, the statement of SGMH was not sufficient to admit the patient as a BPL.

(xi) There is inconsistency in the statements of the staff. Further, incorrect treatment was administered to Shanti Devi by a Obstetrician, Dr. Yashoda Karru. The hospital claims that the patient left against medical advice, however, it is unclear whether the hospital clearly explained the situation to the patient's relatives, considering that the patient was immediately rushed to SGMH. Further, was a private

corporate hospital sufficiently sensitive and informed in the manner that BPL patients should be interacted with?

(xii) There is no evidence that she received counselling and follow-up after discharge from hospital (after her 5th pregnancy). However, her relatives have positively affirmed that she and her husband were counseled about family planning before they were discharged from Deen Dayal Hospital. When questioned, Kishan said that he was informed that another pregnancy would lead to serious problems and will be a threat to her life. Lakshmi Mandal and his wife, Malati blame Kishan for not taking precaution to prevent pregnancy. Notably, despite having several occasions/ opportunities to do so, hospitals failed to refer Shanti Devi for counseling on family planning.

(xiii) Subcentre records could not reveal that her pregnancy was registered, or that she received any facilities or advice. Her maternal death was not audited either, despite the Government Circular. Research shows that a small proportion of the maternal deaths are actually reported. ANM Kaushalya said that she did not report Shanti Devi's maternal death as she was afraid that she would be blamed for neglect.

(xiv) 102 services toll free number was not used. Shanti Devi's family hesitated to go to the hospital and feared that they will not be received.

One important finding in the report submitted by Dr. Prakasamma is that the primary cause of Shanti Devi's death was postpartum haemorrhage due to retained placenta.

Fatema and Alisha

29.1 The facts as narrated in the companion writ petition, W.P. No. (C) 10700 of 2009, are that Fatema, daughter of the Petitioner Jaitun, is a poor,

uneducated woman and suffers from epilepsy fits. She is homeless, living under a tree in Jangpura in New Delhi. Her husband abandoned her after she became pregnant. On 30th December 2008 and 17th March 2009, Fatema went to a Maternity Home run by the Municipal Corporation of Delhi (MCD), Jangpura for vaccination, and inquired about the cash benefits that she could avail upon delivery. However, she received no response much less assistance from the authorities.

29.2 On 29.5.2009 Fatema, delivered her child Alisha, in full public view, without access to skilled health care and medical guidance. Fatema delivered her child Alisha under a tree. Subsequently, on the same day, the Petitioner Jaitun informed the Maternity Home of the delivery. However, no visit was made by the staff of the Hospital.

29.3 On 3rd June 2009, the Petitioner, Fatema and her child went to the Maternity Home, MCD for the child's vaccination, however, the child did not undergo any medical check-up under the Service Guarantee of NRHM, neither was she given advice, nor was she given medicines. On 5th June 2009, Fatema was advised that she is anemic, without conducting any blood test on her. She was administered medicines and issued a discharge slip, which the staff of the Maternity Home explained, was the only way for her getting a birth certificate for her daughter and to get a cash assistance under the JSY. The particulars in the slip were in English and therefore unintelligible to Fatema. Jaitun and Fatema made a number of visits thereafter to the Maternity Home but were refused payment. It appears that ultimately Jaitun was able to get Rs. 550 from the Maternity Hospital

primarily on account of the intervention of a social activist. It is the petitioner's case that despite repeated requests, Fatema never received transportation costs to and from the Maternity Hospital.

29.4 In these circumstances, the present writ petition was filed by Fatema's mother Jaitun praying for compensation, proper implementation of schemes and providing Fatema and her daughter with nutrition and health care. On the date of filing the writ petition, Fatema's health condition had significantly deteriorated (anemia and epilepsy fits), but, she had not been visited by the Anganwadi worker or by the ANM. Neither Fatema nor her child received the benefits under the ICDS scheme, the AAY scheme and the NMBS scheme.

29.5 It is submitted in the writ petition that, the AWC at Nizam Nagar, Nizamuddin was visited on three occasions by a social activist associated with an NGO, however, the AWC would remain closed most of the time, it would be open for about one hour every day. In this one hour, children were given some halwa. However, it is submitted that this halwa scarcely met their dietary needs. The community residing around the AWC was not aware of the services which AWC was to provide. The AWC did not run in a separately rented place, but in a room, where a family permanently resides. The petition points out that the AWC has a highly unsatisfactory infrastructure. There is no board outside the AWC, which would signify its presence.

29.6 On the date of filing this petition, Fatema's daughter Alisha's health

was deteriorating, as she had not received milk (breast milk or through bottles). The petitioner stated that Fatema herself was very ill and did not produce breast milk. There was no money for buying milk.

29.7 On 8th January 2010, this Court passed the following order:

> "**W.P.(C) No. 10700 of 2009**
>
> 1. Among the grievances still outstanding are that the Petitioner's daughter Ms. Fatema has not yet been given the Antyodaya Anna Yojana ('AAY') card. Today the said card has been brought to the Court by Ms. Usha Rani (Lady Health Visitor) of the Municipal Corporation of Delhi ('MCD'). It is stated that the said card had been taken for stamping on it the name of the ration shop from which the allocation can be availed of by Ms. Fatema. It is assured by Ms. Zubeda Begum, learned counsel appearing for the GNCTD that she will issue necessary instructions to ensure that if Ms. Fatema approaches the ration shop named in the AAY card on 11th January 2010, she will be given her entitlement of grain.
>
> 2. The next aspect is about the medical assistance that Ms. Fatema requires for herself and her child. It is stated that her breast milk stopped immediately after delivery and has not recommenced due to malnutrition. Although she underwent a check-up in the department of Neurology of G.B.Pant Hospital earlier, she could not visit the said hospital again since no ambulance was provided to her. It is stated by Ms. Usha Rani that Ms. Fatema along with the social workers can report to the Maternity Home, MCD, Jangpura at 10 am on 12th January 2010 and every arrangement will be made to ensure that Ms. Fatema and her child get appropriate medical assistance on 12th January 2010 itself. If so warranted, an ambulance will be arranged for Ms. Fatema to be taken to the G.B.Pant Hospital for further check-up and treatment.

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

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

5. List on 13th January 2010.

6. A copy of this order be given dasti under the signature of the Court Master to learned counsel for the parties.

7. The Registry will ensure that a copy of this order is delivered today itself by a special messenger of this Court to the Health Secretary, GNCTD and the Joint Secretary, Ministry of Health, Union of India."

Thereafter on 13th January 2010 Fatema received the AAY card and the cash benefit of Rs. 500 under the NMBS.

Response of the Union of India and the States

30. The Union of India, the GNCTD and the State of Haryana have filed their responses to the petitions and to the specific queries posed by this Court in its orders.

31. The Government of India in its affidavit dated 26th May 2010, by the Under Secretary in the Ministry of Health and Family Welfare, Government of India stated, "regarding the two specific cases, the State Governments of NCT of Delhi and Haryana are replying on the status of implementation of the order of the Supreme Court." The stand otherwise of the Government of India is that the responsibility for implementation of the schemes is essentially with the State governments. Although it is claimed that there is some kind of a review undertaken of the working of the schemes in the states, and this has been provided for in the JSY document it is not in dispute that these two instances were not brought to the notice of the central government. There does not also appear to be any inbuilt mechanism for corrective action, restitution and compensation in the event of the failure of any beneficiary to avail of the services under the schemes. This, despite the fact that under the NRHM there are service guarantees and that JSY document also requires strict implementation by the state governments.

31. The Government of NCT of Delhi has filed an affidavit of its Director, Health & Family Welfare Department giving information on how the NCT of Delhi has implemented the schemes. As regards the facts of these two petitions the response of the Department of Women and Child Development, GNCTD is that Alisha has been registered in the AWC of the ICDS Nizamuddin Project, and is getting weaning food (panjiri) as take home ration worth Rs. 5/- per day within the prescribed Calorie and Protein norms (500 Calories and 12-15 Gms. of Protein). As regards Archana, it is stated that the child is eligible for supplementary nutrition under ICDS Scheme and

health services can be availed by her in convergence with the Health Department by approaching the nearby AWC in Nangloi where she is residing. It is further stated that the health services are being provided to Alisha in convergence with the local MCD dispensary. She has already received due dosages of DPT and Measles. Her mother Fatima is also getting medical treatment from the GB Pant Hospital after being referred to the local MCD dispensary according to the CDPO Nizamuddin.

32. The Government of Haryana has filed an affidavit of its Programme Officer, Dist. Integrated Child Development Services Cell, Faridabad. While referring to the ICDS scheme it states, "that the child (baby of Shanti Devi and Kishan Mandal) can be benefitted to the above mentioned Schemes, run by the Women and Child Development Department, Haryana provided, she fulfils the eligibility criteria."

33. In the additional affidavit of the Civil Surgeon, Faridabad dated 1st June 2010 with respect to the JSY scheme, it is stated that "Smt. Shanti Devi was advised by the concerned ANM (Mrs. Kaushalya) in Nov./Dec. 2009 and she was given T.T. injection and iron tablets." According to this affidavit "the ANM advised and ready to help Smt. Shanti Devi to get checked at PHC Palla. But Smt. Shanti Devi refused to go. The ANM also advised her husband to get the BPL card and SC certificate so that they can avail the benefits of JSY (GOI) and JSY (State). But her husband was reluctant."

34. The affidavit states that the expected date of delivery was 20th March 2010. It was a premature delivery. The baby was born on 20th January

2010. Shockingly, the affidavit states: "It was an unexpected and unwanted event. Therefore, she could not get any help/assistance from ANM and ASHA."

Analysis of facts

35. As Dr. Prakasamma's report, which has not been countered by the Respondents, shows the direct cause of Shanti Devi's death was the Extensive Haemorrhage (PPH) with Retained Placenta. However, there were many indirect and contributing factors to her death, which broadly include, her dismal socio-economic status which denied access to needed resources and services, and her poor health condition which is a culmination of anemia, tuberculosis and repeated, unsafe pregnancies. The findings of Dr. Prakasamma have already been referred to earlier.

36. Dr. Parkasamma's report shows that Smt. Shanti Devi was a high risk patient and advised by the Doctors not to go in for a sixth pregnancy. During her fifth pregnancy in 2008, she had an intrauterine death, retained placenta leading to coagulation disorder. She had also T. B., Bronchiectasis and breathing difficulty. She had fracture of Humerus and multiple fracture ribs. She therefore needed to be constantly monitored and counselled.

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

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.

38. In Shanti Devi's case also an attempt was made to show that an ASHA visited her and the photocopy of the register maintained by such ASHA was produced. This however does not inspire confidence as it does not appear to have been countersigned or checked. Clearly, closer to the expected date of delivery i.e. 20th March 2010, the visits by the ASHA were either non-existent or infrequent. Likewise in the case of Fatema, there is no record of her being visited by any ASHA or being given assistance for home delivery.

39. A significant feature of both cases is that both women delivered their babies outside of the institution. The schemes envisage that even for home deliveries, assistance has to be provided to the pregnant women. In the case of Fatema this Court has been shown a report of Dr. Indrani Sharma which appears to suggest that she delivered a baby in her jhuggi. It is not

understood on what basis this report has been prepared. It is however contradicted by the photographs enclosed with the petition which indicate that the baby was indeed delivered under a tree. Be that as it may, there is no record of immediate post delivery assistance being afforded to Fatema and Alisha as mandated by the JSY.

40. Both the cases point to the complete failure of the implementation of the schemes. With the women not receiving attention and care in the critical weeks preceding the expected dates of delivery, they were deprived of accessing minimum health care at either homes or at the public health institutions. As far as Shanti Devi is concerned, the narration of facts concerning her fifth and sixth pregnancy show that she was unable to effectively access the public health system. 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.

41. However, what is clear is that there does not appear to be a system requiring increased visits by the ASHA or ANM, closer to the actual expected date of delivery. Unless this is done, it may be difficult for a pregnant woman with complications to be immediately shifted to an institution for an institutional delivery. With the possibility of babies being delivered prematurely not being able to be completely ruled out, the increased visits by the ANM at least two months prior to the expected date

of delivery would ensure the arrangement of ambulance to shift the woman who is facing complications or who may develop labour pain to be immediately shifted to hospital. The woman may require delivery through cesarean operation in which case she also would be required to move to the Government health center with such facilities without delay.

42. It was sought to be urged that the ANM advised Shanti Devi that she should come for institutional delivery and she simply refused. With Shanti Devi not around anymore, it is very difficult to verify this kind of a statement. Be that as it may, given that an important component of the JSY is counseling of a pregnant woman, if during the stage of pregnancy and needing critical care, a woman is unwilling to avail of such services, it would be incumbent upon the ASHA or the ANM concerned to immediately report the matter to the ANM/MO who will then make such efforts by counselling the pregnant woman and impressing upon her family to shift her to the hospital. This was not done in Shanti Devi's case.

43. As far as the NMBS is concerned, it envisages a one-time cash assistance of Rs.500/- at least 8 to 12 weeks prior to the delivery. While after the Court's order Fatema received the cash assistance, Shanti Devi died without receiving it. Even now the State of Haryana has not paid the said cash assistance to the legal representatives of Shanti Devi.

Confusion regarding cash assistance under the NMBS

44. There has been a doubt whether cash assistance under the NMBS is independent of the cash assistance under the JSY. The order dated 20th

November 2007 of the Supreme Court leaves no manner of doubt that this is a separate benefit and has to be provided 8 to 12 weeks prior to the actual date of delivery.

45. The Central Government has taken shelter under paragraph 15 of the order dated 20th November 2007 of the Supreme Court which reads as under:

> "15. At this juncture it would be necessary to take note of certain issues which have relevance, it seems from the scheme that irrespective of number of children, the beneficiaries are given the benefit. This in a way goes against the concept of family planning which is intended to curb the population growth. Further the age of the mother is a relevant factor because women below a particular age are prohibited from legally getting married. The Union of India shall consider this aspect while considering the desirability of the continuation of the scheme in the present form. After considering the aforesaid aspects and if need be, necessary amendments may be made."

46. Pursuant to the above directions, an interlocutory application was filed in the Supreme Court seeking modification of its mandatory directions in the order dated 20th November 2007 to the effect that "the Union of India and all State Governments would continue with the NMBS" and "ensure that all BPL pregnant women get cash assistance 8 to 12 weeks prior to the delivery." Further it was mandated that the amount shall be Rs.500/- per birth irrespective of number of children and the age of the woman. Yet, after filing the interlocutory application, in which no order has been passed as yet by

the Supreme Court, the State Governments have been instructed to continue following the earlier patterns of denying cash assistance after two live births. Clearly, this is a confusion created by the Central Government at two levels. First by treating the cash assistance under the NMBS as forming part of the cash assistance under the JSY and, therefore, applying the same yardstick. Secondly, in restricting the cash benefit under the NMBS to two live births when clearly the Supreme Court's order says to the contrary.

47. As a result of the above confusion created by the Central Government, millions of pregnant women across the country have, despite the order dated 20th November 2007, been deprived of this cash assistance. While Rs.500/- may not seem substantial to a salaried middle class person in this country but it means a lot to a pregnant woman struggling to make ends meet.

48. An argument was advanced by Mr. A.S. Chandhiok, learned Additional Solicitor General ('ASG') by drawing an analogy with the allotment of alternate accommodation to a slum dweller, that there is an apprehension that the benefit under the scheme would be 'misused'. This Court finds this apprehension to be misplaced. Given the status of the facilities available in Government hospitals and primary health centers across the country, it is very unlikely that any person who can otherwise afford health care is going to 'misuse' these facilities. On the other hand, when it comes to the question of public health, no woman, more so a pregnant woman should be denied the

facility of treatment at any stage irrespective of her social and economic background. This is the primary function in the public health services. This is where the inalienable right to health which is so inherent to the right to life gets enforced. There cannot be a situation where a pregnant woman who is in need of care and assistance is turned away from a Government health facility only on the ground that she has not been able to demonstrate her BPL status or her 'eligibility'. The approach of the Government, both at the Centre and the States, in operationalising the schemes should be to ensure that as many people as possible get 'covered' by the scheme and are not 'denied' the benefits of the scheme. Instead of making it easier for poor persons to avail of the benefits, the efforts at present seem to be to insist upon documentation to prove their status as 'poor' and 'disadvantaged'. This onerous burden on them to prove that they are the persons in need of urgent medical assistance constitutes a major barrier to their availing of the services. This is one reason why the coverage under the schemes has been poor in all these years and has required active intervention by the Supreme Court.

49. The affidavits filed both by the Government of Haryana as well as the GNCTD reflect that the coverage of beneficiaries under the schemes is indeed improving. Yet the artificial distinction drawn between HPS which presumably include Delhi and Haryana, and the LPS, may actually result in the pregnant women in urgent need in Delhi and Haryana being deprived of it. While the logic of depriving cash assistance beyond two live births even in HPS cannot be justified

on any rational basis particularly since women in the Indian social milieu have very little choice whether she wants to have a third child or not, the other benefits under the JSY and other claims obviously cannot be denied to any woman irrespective of the number of live births.

50. Till this Court passed the necessary orders, the AAY card was not given to either Fatema or to the family of Shanti Devi. Sadly during her life time Shanti Devi did not get the benefit offered under the AAY or the ICDS. This is a major failure which aggravated the causes that ultimately led to her death. As far as Fatema was concerned, after the delivery of the baby under a tree, the GNCTD appears to have got its act together to provide her with an AAY card and to ensure that her baby Alisha is receiving good food at the Aanganwadi Center of the ICDS. All this happened, of course, only after the intervention of this Court.

Reparations and reliefs

51. The question that next arises is how reparations be made for the failure to implement the schemes in both these cases during the time when both women were pregnant. Fortunately in Fatema's case the baby and the mother survived. In Shanti Devi's case she died giving birth to the child at her residence in Faridabad. This was the second time she was being denied the assistance under the scheme. 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.

52. It was not denied by learned counsel appearing for the Government of Haryana, the GNCTD as well as the Central Government that as of now there is no inbuilt component for reparations under the schemes. Given that the budget outlay of the schemes is in several hundreds of crores, it is indeed surprising that there is no inbuilt component for reparations. The Petitioners on their part have asked that compensation be awarded to the family of Shanti Devi for her death which resulted as a failure by the Government of Haryana, and the GNCTD to provide the benefits under the above schemes. Likewise, compensation has been claimed for Fatema as well.

53. It may be difficult to quantify the actual loss suffered by either family as a result of the failure by the State Government to deliver the benefits under the schemes to each of these women during their pregnancies. What is clear in Shanti Devi's case is that the maternal mortality was clearly avoidable.

54. In the case of Fatema soon after the baby was delivered, she required nutrition and supplements which were denied till the Court's intervention. Even the ICDS benefits were given only after the Court's intervention. It is well possible that but for the Court's intervention, the baby and the mother may have been deprived of the

benefits which would have caused irreparable injury and possibly loss of life.

55. Having considered these circumstances, the Court issued the following directions as regards Writ Petition (C) No. 8853 of 2008 concerning the family of baby Archana, the daughter of late Shanti Devi.

(a) The GNCTD will refund forthwith to Shanti Devi's husband Rs.1,000/- charged by the DDU Hospital from Shanti Devi for her treatment since that treatment was free.

(b) The sum of Rs.500/- will be paid forthwith to Shanti Devi's husband by the GNCTD under the NMBS.

(c) The AAY card will be made forthwith for the family of baby Archana.

(d) Under the Apni Beti Apna Dhan Scheme, the State of Haryana will give Rs.500/- to Archana through her father. Indira Vikas Patras of Rs.2,500/- in the name of baby Archana forthwith be handed over to her father.

(e) Under the Balika Samridhi Yojana Scheme launched by the Government of India, a sum of Rs.500/- being given as post-birth grant to the mother will now be given to Archana's father. In addition, the following benefits will be ensured during Archana's growing years:

"Class	Amount of Annual Scholarship
I-III	Rs. 300/- per annum for each class
IV	Rs. 500/- per annum
V	Rs. 600/- per annum
VI-VII	Rs. 700/- per annum for each class
VIII	Rs. 800/- per annum
IX-X	Rs. 1,000/- per annum for each class"

(f) Under the NFBS, Shanti Devi will be recognized as a 'primary bread winner' and a sum of Rs.10,000/- will be given to her husband and to the children forthwith.

(g) In addition to the above, for the avoidable death of Shanti Devi a sum of Rs.2.4 lakhs be paid by the State of Haryana within a period of four weeks to the family of Shanti Devi of which Rs. 60,000/- will be paid to Shanti Devi's husband and Rs.60,000/- each be kept in a fixed deposit in a nationalised bank in Delhi in the names of Shanti Devi's two sons and Archana which will be kept renewed till each child completes 21 years. The interest on the fixed deposits will be credited to the savings bank account of their father and after each child attains majority to their respective savings bank accounts. After their 21st year, each child can encash the fixed deposits.

56. In W.P.(C) No. 10700 of 2009, pursuant to the orders passed by the Court, Fatema has been paid Rs.500/- cash assistance under the NMBS. She was given an AAY card. A complaint was made that she

has not been given the 35 Kg. of grains, sugar and kerosene oil for the last three months. An officer from Food & Supplies Department of the GNCTD present in the Court assured that he will have this complaint immediately examined and ensure that Fatema receives the full quota of 35 Kg. under the AAY card.

57. Fatema is a patient of epilepsy and shall continue to receive her medication every 15 days from the Maternity Home of the MCD at Jangpura. She will undergo a medical check-up every two months at the G.B. Pant Hospital. If required, an ambulance will be arranged at the Maternity Home, Jangpura for taking her to the G.B. Pant Hospital for future check-ups.

58. The baby Alisha is entitled and shall be granted the comprehensive benefits under the ICDS in terms of the orders dated 20th November 2007 passed by the Supreme Court in W.P.(C) No.196 of 2001. There appears to be some correction required to be made in the birth certificate issued for Alisha. The Respondent MCD will render necessary assistance to Fatema to have the correction carried out.

59. Alisha is entitled to all the benefits under the BSYS as recast by the Government of India in 1999-2000. Accordingly, the following benefits shall be extended to baby Alisha:

"Class Amount of Annual Scholarship

I-III	Rs. 300/- per annum for each class
IV	Rs. 500/- per annum
V	Rs. 600/- per annum
VI-VII	Rs. 700/- per annum for each class
VIII	Rs. 800/- per annum
IX-X	Rs. 1,000/- per annum for each class"

60. In addition to the above, the GNCTD has announced a Ladli Scheme under which financial deposit in the sum of Rs.10,000/- has to be made in the name of the girl child after 1st January 2008. The said benefit will be extended to Alisha within a period of four weeks from today.

61. For the violation of the fundamental rights of Fatema by being compelled to give birth to Alisha under a tree which is only on account of the denial of basic medical services to her under the various schemes, the MCD and the GNCTD will jointly and severally be liable to pay her compensation in the sum of Rs.50,000/- within a period of four weeks from today. The said amount will be placed in a fixed deposit for a period of three years in the name of Fatema in an account to be opened in a nearby nationalized bank with the facility of transferring the interest accrued thereon every quarter to her savings account which can even be withdrawn by her. She would be able to encash the fixed deposit after a period of three years.

Shortcomings in the implementation of the schemes

62. This Court notices the following shortcomings in the working of the

schemes:

(i) There is no assurance of 'portability' of the schemes across the states. In the present case, Shanti Devi travelled from Bihar to Haryana and then to Delhi. In Haryana she was clearly unable to access the public health services. At Delhi she had to once again show that she had a BPL card, and on being unable to do so, she was denied access to medical facilities. For the migrant workers this can pose a serious problem. Instructions will have to be issued to ensure that if a person is declared BPL in any state of the country and is availing of the public health services in any part of the country, such person should be assured of continued availability of such access to public health care services wherever such person moves.

(ii) There is confusion on whether the cash assistance under the NMBS scheme is independent of the cash assistance under the JSY scheme, despite the Supreme Court making this unambiguously clear by its order of 20th November 2007 in the case of ***PUCL v. Union of India***. Further it appears that benefit under the NMBS is being denied to women who have had more than two live births and to women who are under 19 years of age, although the Supreme Court's order dated 20th November 2007 makes it clear that such benefits should be made available irrespective of the number of live births or the age of the mother. The necessary clarification requires to be immediately issued by the Central Government to all the State Governments in this regard so that pregnant women across the country are not denied cash assistance.

(iii) There is an overlap of the schemes. The ICDS is administered by the Department of Women and Child Development of the State, the NRHM by the Ministry of Health at the centre and JSY by the Health Ministries of the States. There must be an identified place which the women can approach to be given the benefits under the various schemes. In other words, a pregnant

woman or a lactating mother should not have to run to several places to get benefits under the schemes.

(iv) The system of administering the IWC under the ICDS requires to be overhauled. AWCs even in Delhi appear to operate from single rooms which are inadequate for the number of children who have to be served at the AWC. AWCs are seen to be in a deplorable condition. There is nothing in the form of any label/board to indicate their presence. They also do not appear to have the necessary equipment to carry out the necessary tests. In the rural set up, it should be possible to have a monthly camp held at an identified place where the pregnant women and young children can undergo health check-up.

(v) The system of referral to private health institutions has to be improved. Safe and prompt transportation of pregnant women from their places of residence to public health institutions or private hospitals and vice-versa needs to be ensured. The critical days and hours prior to the expected date and time of delivery can be a matter of life or death for a pregnant woman. If adequate ambulance services are not available at that stage, many a life will be needlessly lost. The two cases here show the Court orders were required at various times even to remove the baby for critical care from one hospital to another. Even in places like Delhi, the ambulance and transport services require to be augmented and improved significantly.

(vi) The NFBS envisages the payment of sum of Rs. 10,000/- in the event of death of the 'primary bread winner.' It is also necessary to recognize a woman in the family who is a home maker as a "bread winner" for this purpose. In the event of a maternal death, the family should get the cash benefit under the NFBS. It should be ensured that this is made available to her legal heirs as per their legal entitlement. Necessary instructions clarifying this position will have to be issued by the Central

Government to the State Governments.

(vii) The statistics furnished by the State Governments on the performance of the JSY show the number of institutional deliveries but do not indicate what percentage of the total number of deliveries in the State they constitute. Only when such information is available and provided under the schemes, the categorization of States as HPS and LPS is possible. The Central Government must insist on this kind of information for meaningful assessment of the working of the schemes.

(viii) On the working of the AAY, it appears that the benefits are not reaching to the pregnant women, particularly those who migrate from one State to another. This problem will require urgent attention at the hands of the Central Government, the State Governments and the UTs. There is also a problem of portability of the AAY benefit. Unless the poor woman is assured of the AAY benefits notwithstanding having to travel from one State to another, the scheme cannot be said to be effective.

(ix) The present cases afford an opportunity to the Central Government, the State Governments and the UTs, particularly the State of Haryana and the GNCTD, to put in place corrective measures.

Other directions

63. There are certain general directions which also become necessary to be issued. It is made clear that these directions are only to further effectuate the mandatory orders already issued by the Supreme Court from time to time in W.P. (C) No. 196 of 2001 relevant portions of which have already been extracted hereinbefore. These directions are necessary to ensure that the benefits under the various schemes are not denied to the beneficiaries and

that assistance is provided promptly at the nearest point where it can be accessed.

64. The health departments of the GNCTD and the State of Haryana will devise formats of registers to be maintained by Medical Officers who are supervising the work of ANMs and the ASHAs. Each ASHA will maintain a proper log of all her visits and have a checklist of the various benefits to be given in terms of the service guarantees of NRHM including ante natal care, essential and emergency obstructive services, referral services, post natal care, child health, family planning and contraception. Each of the visits by an ASHA to a woman during pregnancy and thereafter will be countersigned by an ANM and periodically at least once in 10 days be checked also by the MO.

65. Every ASHA/ANM will report to the MO if any beneficiary is declining the assistance provided or refusing to take medicines or is reluctant to go in for institutional delivery. The MO will then either undertake a personal visit to the woman concerned or issue necessary instructions for further counseling such woman and make a special note thereof in her record. At the District level and thereafter at the State level there must be a periodical review of the performances of the ASHAs and ANMs, district wise. It must be ensured that the cash assistance under the various schemes including the JSY and NMBS is promptly provided to each beneficiary.

66. A review be undertaken of the issuance of AAY card in terms of the orders of the Supreme Court. It should be ensured that every eligible person/family/child is granted the benefit under the AAY.

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

68. Ideally special cells have to be set up within the health departments of the Central and State Government for monitoring the implementation of the schemes on a regular basis.

69. The Government of India on its part will immediately issue a corrective to the earlier instructions issued in October 2006 in relation to the JSY as well as instructions relating to the cash assistance under the NMBS so that it is not denied to any woman irrespective of the number of live births or age. There shall be strict compliance of the orders of the Supreme Court in this regard.

70. 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.

71. The petitions are disposed of with the above directions.

S. Muralidhar J.

4th June 2010
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