GAHC020000352016

THE GAUHATI HIGH COURT
(HIGH COURT OF ASSAM, NAGALAND, MIZORAM AND ARUNACHAL PRADESH)

KOHIMA BENCH

W.P.(C) No. 179/2016

Moba Changkai,
S/o Shahyam, H/No-84,
Yongkhoang Khel, Monyakshu Village, Mon
Monyakshu, Nagaland.

-**Versus**-

1. The State of Nagaland through the Chief Secretary,
Government of Nagaland, Kohima, Nagaland.

2. The Commissioner & Secretary,
Govt. of Nagaland, Health & Family Welfare Department, Kohima, Nagaland.

3. The Principal Director,
National Health Mission (NHM),
Directorate of Health & Family Welfare, Kohima, Nagaland.

4. The Mission Director,
National Health Mission (NHM),
Directorate of Health & Family Welfare, Kohima, Nagaland.

5. The Commissioner & Secretary, Govt. of Nagaland,
Department of Social Welfare, Kohima, Nagaland.

6. The Director,
Department of Social Welfare, Kohima, Nagaland.

7. The Medical Superintendent,
Mon District Hospital, Mon, Nagaland.

8. Chief Medical Officer,
Mon District Hospital, Mon, Nagaland.

9. Union of India
Represented by the Secretary, GOI
Ministry of Health and Family Welfare,
New Delhi.

-BEFORE-
HON'BLE MR. JUSTICE SONGKHUPCHUNG SERTO

Advocate for the petitioner : Ms. K. Kikhi,
Ms. Neiteo Koza,
Mr. Pakinrichapbo

Advocate for the respondent Nos.1,2,5,6,7 & 8 : Ms. A. Ayemi, Govt. Adv.

Advocate for respondent Nos. 3 & 4 : Mr. N. Mozhui,
Ms. N. Rupreo

Advocate for respondent No.9 : Mr. Yangerwati, C.G.C

Date of hearing : **05/09/2019**

Date of judgment : **15/11/2019**

JUDGMENT & ORDER (CAV)

Heard Ms. K. Kikhi, learned counsel assisted by Mr. Pakinrichapbo, learned counsel appearing for the petitioner. Also heard Ms. A. Ayemi, learned Government Advocate appearing for the State respondent Nos.1, 2, 5, 6, 7 & 8, Mr. N. Mozhui, learned counsel appearing for respondent Nos. 3 and 4 and Mr. Yangerwati, learned C.G.C. for respondent No.9.

2. This writ petition is filed by the son of an unfortunate woman who died while she was being taken to district hospital for child delivery, praying for a direction to the respondents No. 1 to 4 to pay compensation for the death of his mother and the unborn baby, and also praying for a direction directing the respondent Nos. 5 & 6 to pay him and his family a sum of Rs.20,000/- as per entitlement under the National Family Benefit Scheme (in short, NFBS).

3. The case of the petitioner as submitted by his learned counsel Ms. Kikhi is as follows;

That his mother namely Lt. Bema, who was pregnant with the 7th child, had labour pain at about 2 A.M. of 11/07/2016 and during the course of the labour, one arm of the baby emerged from the birth canal with the help of his father but since the baby could not fully come out they looked for a vehicle for hire and when they found it they started straight away for the district hospital at Mon which is about 130 Kms away from their village Monyakshu. But while they were still on the way his mother died.

That as per the Indian Public Health Standards (IPHS) Guidelines for Sub-Centres, Revised 2012, published by the Office of the Director General of Health Services, Ministry of Health & Family Welfare, Government of India, there are two categories of Sub-Centres i.e. Type-A and Type-B and, in the Type-B Sub-Centres basic facilities for conducting deliveries and new born care are to be made readily available. Therefore, the Sub-Centre in their village, which is Type-B Sub-Centre is suppose to have all those basic facilities for conducting deliveries. But since the Sub-Centre was also closed on that day and no proper facilities for delivery was available, his family were left with no choice but to take his mother to the district hospital.

That, as per the Janani Suraksha Yojana (JSY, in short), which is a scheme for safe motherhood intervention under the National Health Rural Mission, (in short, NHRM), an undertaking of the Ministry of Health & Family Welfare, Government of India, Maternal Health Division and implemented in the State of Nagaland through the nodal agency; Nagaland State Health Society, a minimum of one ASHA is to be made available to such Sub-centres for effective implementation of the scheme and to perform the following duties;

1. *Identify pregnant woman from BPL families as a beneficiary of the scheme and report to the ANM for registration.*

2. *Assist the pregnant woman to obtain BPL certification if BPL card is not available.*
3. *Provide and/or help the women in receiving at least three ANC, two TT injection, IFA tablets.*
4. *Counsel for institutional delivery.*
5. *Escort the beneficiary women to the pre-determined health centre and stay with her till the woman is discharged.*
6. *Arrange to immunize the newborn till the age of 10 weeks.*
7. *Register birth or death of the child or mother with the ANM/MO.*
8. *Post natal visits within 7 days of pregnancy and track mother's health.*
9. *Counsel for initiation of breastfeeding within one-hour of delivery and its continuance till 3-6 months, family planning.*

And work of the ASHA is to be assessed based on the number of pregnant women she has been able to motivate to deliver in a health institution.

That as given in the scheme one amongst the duties of ASHA is to identify pregnant women from BPL families as beneficiary of the scheme and report to the ANM for registration. However, the ASHA of the village attached to the Sub-Centre never identified the petitioner's mother to enable her to avail the benefits of the scheme.

Moreover, as per the guidelines given under the JSY, Sub-Centres in tribal and hilly districts are to be well equipped to make them better options for normal deliveries so that people settled in those places are encouraged to go for institutional deliveries so as to reduce maternity and infant deaths. But since the Sub-Centre at Monyakshu village was never equipped properly such institutional deliveries could not be conducted, leaving no choice for the villagers but, to continue delivering at home or at other health centres available in the district. Had such facilities been made available, the petitioner's mother would have availed

the same and her life and the life of the unborn baby could have been saved.

4. It is also submitted by the learned counsel for the petitioner that the work of the ANM and ASHA posted at the Sub-Centre should have been supervised by the M.O. in-charge of the PHC at Changlangshu village under which the Sub-Centre falls. However, due to lack of supervision from the M.O. in-charge of the PHC who is in turn under the supervision of the higher authorities both at the district and State level, the Sub-Centre in the village of the petitioner was not in proper functioning mode. As such, the villagers of the petitioner, including his own mother were deprived of the facilities which ought to have been made available under the various schemes of the NHM. It is also submitted that providing of proper health facilities by the State comes under the ambit of Article 21 of the Constitution of India. Therefore, the State is duty bound to provide robust health facilities so that citizens not only survive but live in health and dignity.

5. The learned counsel further submitted that under the NFBS, members of a family where death occurs are given a sum of Rs.20,000/- if the deceased is the bread earner of the family and or if the deceased is a woman who is the homemaker of the family. Therefore, the Department of Social Welfare, Nagaland should have extended the benefit of the scheme to the family of the petitioner by granting a sum of Rs.20,000/- but this has not been extended. As such, the petitioner has been compelled to also make a mention of the same and pray for issuance of appropriate direction directing the respondent Nos. 5 and 6 to pay him of his family a sum of Rs.20,000/- under the scheme. In support of her submission, the learned counsel has cited the judgments passed in the following cases. The name of the parties, the citations and relevant paragraphs numbers given by the learned counsel for the petitioner are given here below one after the other;

(**i**). **Nilabati Behera alias Lalita Behera** –versus- **State of Orissa and Others,** reported in **(1993) 2 SCC 746**, para-12.

"12. In view of the decisions of this Court in Rudul Sah v. State of Bihar and Another, [1983] 3 S.C.R. 508,Sebastian M. Hongray v. Union of India and Others, [1984] 1 S.C.R. 904 and [1984] 3 S.C.R. 544,Bhim Singh v. State of J&K [1984] Supp. S.C.C. 504 and [1985] 4 S.C.C. 677, Saheli, A Women's Resources Centre and Others v. Commissioner of Police, Delhi Police Headquarters and Others, [1990] 1 S.C.C. 422 and State of Maharashtra and Others v. Ravikant S.Patil, [1991] 2 S.C.C. 373, the liability of the State of Orissa in the present case to pay the compensation cannot be doubted and was rightly not disputed by the learned Additional Solicitor General. It ,would, however, be appropriate to spell out clearly the principle on which the liability of the State arises in such cases for payment of compensation and the distinction between this liability and the liability in private law for payment of compensation in an action on tort. It may be mentioned straightaway that award of compensation in a proceeding under Article 32 by this court or by the High Court under Article 226 of the Constitution is a remedy available in public law, based on strict liability for contravention of fundamental rights to which the principle of sovereign immunity does not apply, even though it may be available as a defence in private law in an action based on tort. This is a distinction between the two remedies to be borne in mind which also indicates the basis on which compensation is awarded in such proceedings. We shall now refer to the earlier decisions of this Court as well as some other decisions before further discussion of this principle."

(**ii**). **Sube Singh** –Versus- **State of Haryana and Others**, reported in **(2006) 3 SCC 178**, para- 17.

"17 . It is thus now well settled that award of compensation against the State is an appropriate and effective remedy for redress of an established infringement of a fundamental right under Article 21, by a public servant. The quantum of compensation will, however, depend upon the facts and circumstances of each case. Award of such compensation (by way of public law remedy) will not come in the way of the aggrieved person claiming additional compensation in a civil court, in enforcement of the private law remedy in tort, nor come in the way of the criminal court ordering compensation under section 357 of Code of Civil Procedure.

(**iii**). **A.V. Janaki Amma and Others** –Versus- **Union of India and Others**, passed by the High Court of Andhra Pradesh in **WP No. 7634 of 1997**, para-32 & 33.

"32. In D.K. Basu v. State of West Bengal (supra) the Supreme Court observed that the Constitution of India does not contain express provision for

grant of compensation for violation of fundamental right to life. It evolved the right to compensation in cases of established constitutional deprivation of personal liberty or life. The principle postulates that the Court cannot stop by giving mere declaration that there is infringement of fundamental right. It must proceed further and give a compensatory relief not by way of damages as in civil action, but by way of compensation under the public law jurisdiction for the wrong done, due to breach of public duty by the State in not protecting the fundamental right to life of the citizen as explained by the Supreme Court as under:

Monetary compensation for redressal by the Court finding the infringement of the indefeasible right to life of the citizen is, therefore, a useful and at times perhaps the only effective remedy to apply balm to the wounds of the family members of the deceased victim, who may have been the bread winner of the family..... It is now a well accepted proposition in most of the jurisdiction, that monetary or pecuniary compensation in an appropriate and indeed an effective and sometimes perhaps the only suitable remedy for redressal of the established infringement of the fundamental right to life of a citizen by the public servants and the State is vicariously liable for their acts.....The amount of compensation as awarded by the Court and paid by the State to redress the wrong done, may in a given case, be adjusted against any amount which may be awarded to the claimant by way of damages in a civil suit. (See paragraphs 42, 44 and 55 of AIR).

33. The Apex Court also observed that the claim of compensation based on strict liability is in addition to the claim available in public law for damages for tortious acts of public servants and public law proceedings serve a different purpose than the private law proceedings. State can also recover compensation amount from the public servant who infringed the fundamental right to life".

(**iv**). **Rudul Sah** –Versus- **State of Bihar and Others**, reported in **(1983) 4 SCC 141,** para- 8 to 10.

"8. That takes us to the question as to how the grave injustice which has been perpetrated upon the petitioner can be rectified, in so far as it lies within our power to do in the exercise of our writ jurisdiction under Article 32 of the Constitution. That article confers power on the Supreme Court to issue directions or orders or writs, including writs in the nature of habeas corpus, mandamus, prohibition, quo warranto and certiorari, whichever may be appropriate, for the enforcement of any of the rights conferred by Part III. The right to move the Supreme Court by appropriate proceedings for the enforcement of the rights conferred by Part III is "guaranteed", that is to say, the right to move the Supreme Court under Article 32 for the enforcement of any of the rights conferred by Part III of the Constitution is itself a fundamental right.

9. It is true that Article 32 cannot be used as a substitute for the enforcement of rights and obligations which can be enforced efficaciously through the ordinary processes of Courts, Civil and Criminal. A money claim has therefore to be agitated in and adjudicated upon in a suit instituted in a court of lowest grade competent to try it. But the important question for our consideration is whether in the exercise of its jurisdiction under Article 32, this Court can pass an order for the payment of money if such an order is in the nature of compensation consequential upon the deprivation of a fundamental right. The instant case is illustrative of such cases. The petitioner was detained illegally in the prison for over fourteen years after his acquittal in a full-dressed trial. He filed a Habeas Corpus petition in this Court for his release from illegal detention. He obtained that relief, our finding being that his detention in the prison- after his acquittal was wholly unjustified. He contends that he is entitled to be compensated for his illegal detention and that we ought to pass appropriate order for the payment of compensation in this Habeas Corpus petition itself.

10. We cannot resist this argument. We see no effective answer to it save the stale and sterile objection that the petitioner may, if so advised, file a suit to recover damages from the State Government. Happily, the State's Counsel has not raised that objection. The petitioner could have been relegated to the ordinary remedy of a suit if his claim to compensation was factually controversial, in the sense that a civil court may or may not have upheld his claim. But we have no doubt that if the petitioner files a suit to recover damages for his illegal detention, a decree for damages would have to be passed in that suit, though it is not possible to predicate, in the absence of evidence, the precise amount which would be decreed in his favour. In these circumstances, the refusal of this Court to pass an order of compensation in favour of the petitioner will be doing mere lip-service to his fundamental right to liberty which the State Government has so grossly violated. Article 21 which guarantees the right to life and liberty will be denuded of its significant content if the power of this Court were limited to passing orders to release from illegal detention. One of the telling ways in which the violation of that right can reasonably be prevented and due compliance with the mandate of Article 21 secured, is to mulct its violaters in the payment of monetary compensation. Administrative sclerosis leading to flagrant infringements of fundamental rights cannot be corrected by any other method open to the judiciary to adopt. The right to compensation is some palliative for the unlawful acts of instrumentalities which act in the name of public interest and which present for their protection the powers of the State as a shield. If civilization is not to perish in this country as it has perished in some others too well-known to suffer mention, it is necessary to educate ourselves into accepting that, respect for the rights of individuals is the true bastion of democracy. Therefore, the State must repair the damage done by its officers to the petitioner's rights. It may have recourse against those officers.

(**v**). **Chairman, Railway Board and Others** –Versus- **Chandrima Das and Others**, reported in **(2000) 2 SCC 465**, para- 37, 38, 39, 41 & 42.

"37. Now, Smt. Hanuffa Khatoon, who was not the citizen of this country but came here as a citizen of Bangladesh was, nevertheless, entitled to all the constitutional rights available to a citizen so far as "Right to Life" was concerned. She was entitled to be treated with dignity and was also entitled to the protection of her person as guaranteed under Article 21 of the Constitution. As a national of another country, she could not be subjected to a treatment which was below dignity nor could she be subjected to physical violence at the hands of Govt. employees who outraged her modesty. The Right available to her under Article 21 was thus violated. Consequently, the State was under the Constitutional liability to pay compensation to her. The judgment passed by the Calcutta High Court, therefore, allowing compensation to her for having been gang-raped, cannot be said to suffer from any infirmity.

38. Learned counsel for the appellants then contended that the Central Govt. cannot be held vicariously liable for the offence of rape committed by the employees of the Railways. It was contended that the liability under the Law of Torts would arise only when the act complained of was performed in the course of official duty and since rape cannot be said to be an official act, the Central Govt. would not be liable even under the Law of Torts. The argument is wholly bad and is contrary to the law settled by this Court on the question of vicarious liability in its various decisions.

39. In State of Rajasthan vs. Mst. Vidhyawati AIR 1962 SC 933, it was held that the Govt. will be vicariously liable for the tortious act of its employees. This was a case where a claim for damages was made by the heirs of a person who died in an accident caused by the negligence of the driver of a Govt. vehicle. Reference may also be made to the decisions of this Court in State of Gujarat vs. Memon Mahomed Haji Hasan AIR 1967 SC 1885 and Smt. Basava Kom Dyamogouda Patil vs. State of Mysore AIR 1977 SC 1749. These principles were reiterated in N. Nagendra Rao & Co. vs. State of A.P. AIR 1994 SC 2663 = (1994) 6 SCC 205 and again in State of Maharashtra vs. Kanchanmala Vijaysing Shirke, 1995 ACJ 1021 (SC) = (1995) 5 SCC 659 = JT 1995 (6) SC 155.

40. Reliance placed by the counsel for the appellants on the decision of this Court in Kasturi Lal Ralia Ram Jain vs. State of U.P. AIR 1965 SC 1039 = 1965 (1) SCR 375 cannot help him as this decision has not been followed by this Court in the subsequent decisions, including the decisions in State of Gujarat vs. Memon Mahomed Haji Hasan and Smt. Basava Kom Dyamogouda Patil vs. State of Mysore (supra). The decision in Kasturi Lal's case was also severely criticised by Mr. Seervai in his prestigious book - Constitutional Law of India. A Three- Judge Bench of this Court in Common Cause, A Regd. Society vs.

Union of India (1999) 6 SCC 667 also did not follow the decision in Kasturi Lal's case (supra) and observed that the efficacy of this decision as a binding precedent has been eroded.

41. The theory of Sovereign power which was propounded in Kasturi Lal's case has yielded to new theories and is no longer available in a welfare State. It may be pointed out that functions of the Govt. in a welfare State are manifold, all of which cannot be said to be the activities relating to exercise of Sovereign powers. The functions of the State not only relate to the defence of the country or the administration of justice, but they extend to many other spheres as, for example, education, commercial, social, economic, political and even marital. These activities cannot be said to be related to Sovereign power.

42. Running of Railways is a commercial activity. Establishing Yatri Niwas at various Railway Stations to provide lodging and boarding facilities to passengers on payment of charges is a part of the commercial activity of the Union of India and this activity cannot be equated with the exercise of Sovereign power. The employees of the Union of India who are deputed to run the Railways and to manage the establishment, including the Railway Stations and Yatri Niwas, are essential components of the Govt. machinery which carries on the commercial activity. If any of such employees commits an act of tort, the Union Govt., of which they are the employees, can, subject to other legal requirements being satisfied, be held vicariously liable in damages to the person wronged by those employees. Kasturi Lal's decision, therefore, cannot be pressed in aid. Moreover, we are dealing with this case under Public Law domain and not in a suit instituted under Private Law domain against persons who, utilising their official position, got a room in the Yatri Niwas booked in their own name where the act complained of was committed".

6. Mr. N. Mozhui, learned counsel for the respondent No.4 at the very outset raised two preliminary issues which are as follows;

1. That to invoke writ of mandamus, one must show that a demand has been made but it has been turned down. In this case, the petitioner has never made any demand by submitting a representation to the authorities concerned, therefore, the writ petition can be dismissed on this ground alone.
2. That in every village having health unit there is a village health management committee and they are responsible for the day to day management of the health unit. But they have not been made a party in this case. Further, the ANM and ASHA posted at the

Sub-Centre who are responsible for looking after the Sub-Centre have also not been made a party, therefore, the writ petition is defective and deserves to be dismissed.

Thereafter, Mr. N. Mozhui, submitted that there is no dispute on the fact that there are guidelines issued for implementation of various schemes under the NHM, including the scheme provided for pregnant women both during pre natal and post natal stage and for the new born babies. However, such benefits can be given only if beneficiaries come forward and approach the agencies through whom such benefits are to be given. In this case, the petitioner's mother never came to the Sub-Centre and never approach the ASHA or ANM. Had she approach any of the agencies all the benefits that are due to her would have been provided. Mr. N. Mozhui further submitted that the ASHA of the Sub-Centre at one point of time had approached the deceased mother of the petitioner but she never responded positively. Therefore, the benefits or facilities could not be extended to her.

7. It is also submitted by the learned counsel that the allegation that the Sub-Centre was closed on 11/07/2016 is baseless because from 7th to 13th July 2016 National Immunization Programme under Mission Indradhanush was going on at the Sub-Centre and all those responsible for looking after the Sub-Centre were present during that period. In support of his submission, the learned counsel referred to the letter of the ANM of the Sub-Centre addressed to the CMO, Mon where in it is stated that she was present at the Sub-Centre during the period 7th–13th July 2016 and, the immunization schedule which shows that vaccination was conducted on 12/06/2016, 10/07/2016 and 04/12/2016. The learned counsel also submitted that allegation of the petitioner that no Verbal Autopsy Investigation was conducted after the death of the petitioner's mother is not correct because the same was conducted on 30/11/2016 by the M.O., PHC Changlangshu. In support of his submission, the learned counsel referred to the Verbal Autopsy

Questionnaire for Investigation of Maternal Deaths annexed in the affidavit-in-opposition filed by respondent Nos. 1 to 4, 7 & 8. The learned counsel, thereafter, submitted that the questionnaire shows that the mother of the petitioner during her earlier pregnancy also have never visited the Sub-Centre and all the deliveries of her 6 children were done at home. Therefore, it is likely that she never visited the Sub-Centre for the 7th pregnancy as well, because of their traditional belief and custom.

8. The learned counsel further submitted that the respondents are not opposed to giving compensation as prayed for but the petitioner must first prove that his mother had approached the Sub-Centre and she was not given the facilities she was entitled to. Under public law remedy, for issuance a writ of mandamus, the pre condition that must be fulfilled is, there should be a demand and the demand should have been refused. But since there was no demand from the petitioner's side to the respondents, the writ of mandamus would not lie. In support of his submission, the learned counsel referred to paragraph No.22 of the judgment passed by the Hon'ble Supreme Court in the case of **Rajasthan State Industrial Development and Investment Corporation and Another** –Versus- **Diamond & Gem Development Corporation Limited and Another,** reported in **(2013) 5 SCC 470**. The relevant paragraph No.22 reads as follows;

"22. Hence, direction must be exercised by the Court on grounds of public policy, public interest and public good. The writ is equitable in nature and thus, its issuance is governed by equitable principles. Refusal of relief must be for reasons which would lead to injustice. The prime consideration for the issuance of the said writ is, whether or not substantial justice will be promoted. Furthermore, while granting such a writ, the Court must make every effort to ensure from the averments of the writ petition, whether there exist proper pleadings. In order to maintain the writ of mandamus, the first and foremost requirement is that

the petition must not be frivolous, and must be filed in good faith. Additionally, the applicant must make a demand which is clear, plain and unambiguous. It must be made to an officer having the requisite authority to perform the act demanded. Furthermore, the authority under whom mandamus is issued, should have rejected the demand earlier. Therefore, a demand and its subsequent refusal, either by words, or by conduct are necessary to satisfy the Court that the opposite party is determined to ignore the demand of the applicant with respect to the enforcement of his legal right. However, a demand may not be necessary when the same is manifest from the facts of the case, that is, when it is an empty formality, or when it is obvious that the opposite party would not consider the demand."

9. Ms. A. Ayemi, learned Government Advocate appearing on behalf of the respondent Nos. 5 & 6 submitted that the District Welfare Officer who represent the Department in a district has not been made a party in the writ petition therefore, the writ against the Department would not be maintainable. The learned Government Advocate also submitted that the benefits under NFBS can be given only if the bread earner of the family dies and that too only if local enquiry is made. But, since no application for demand for financial assistance as per the scheme was submitted to the concerned authorities no enquiry has been held.

10. In reply, Ms. K. Kihki, learned counsel for the petitioner submitted that when a writ petition under Article 226 of the Constitution of India is filed regarding violation of fundamental rights, availability of alternative remedy will not bar the Court to consider the prayer of the petitioner in such writ petition. In support of her submission, the learned counsel cited the judgment of the Hon'ble Supreme Court passed in the case of **Himmatlal Harilal Mehta** -versus- **State of Madhya Pradesh and Others,** reported in **AIR 1984 SC 403**, paragraph-9, and the judgment of the Hon'ble Supreme Court in the case of **Harbanslal Sahnia and Another** -Versus- **Indian Oil Corpn. LTD and Others,** reported in

(2003) 2 SCC 107, paragraph-7. The relevant paragraphs are reproduced here below, one after the other;

(**i**) **Himmatlal Harilal Mehta** -Versus- **State of Madhya Pradesh and Others**, para-9.

"9. In our opinion, the contentions raised by the learned Advocate General are not well founded.

It is plain that the State evinced an intention that it could certainly proceed to apply the penal provisions of the Act against the appellant, if it failed to make the return or to meet the demand and in order to escape from such serious consequences threatened without authority of law, and infringing Fundamental Rights, relief by way of a writ of mandamus was clearly the appropriate relief……"

(**ii**) **Harbanslal Sahnia and Another** –Versus- **Indian Oil Corpn. Ltd and Others,** para-7.

7. So far as the view taken by the High Court that the remedy by way of recourse to arbitration clause was available to the appellants and therefore the writ petition filed by the appellants was liable to be dismissed is concerned suffice it to observe that the rule of exclusion of writ jurisdiction by availability of an alternative remedy is a rule of discreation and not one of compulsion. In an appropriate case, in spite of availability of the alternative remedy, the High Court may still exercise its writ jurisdiction in at least three contingencies: (i) where the writ petition seeks enforcement of any of the fundamental rights; (ii) where there is failure of principles of natural justice or (iii) where the orders or proceedings are wholly without jurisdiction or the vires of an Act is challenged….."

11. In reply to the submission of Mr. N. Mozhui. Ms. K. Kikhi, learned counsel for the petitioner submitted that the Verbal Autopsy was done only after the writ petition was filed and not within 24 hours as provided in the Maternal Death Review Guidelines. Therefore, at best, the Verbal

Autopsy conducted by the respondents was only a formality. The learned counsel further submitted that the documents referred to by the learned counsel for respondent No.4 to show that Sub-Centre was opened on 11/07/2016 and the ANM was present at the Sub-Centre does not help the case of the respondents as the same does not indicate the presence of ANM at the Sub-Centre on 11/07/2016. The learned counsel further submitted that it was the duty of the ASHA to visit any pregnant woman in the village and it is not the pregnant woman who should visit the ASHA as per the guidelines. In fact, the ASHA as claimed by the respondents never visited the petitioner's mother and there is nothing to show that she had visited them.

12. Mr. Yangerwati, learned C.G.C submitted that the subject matter relates to the affairs of the State, therefore, Centre has nothing to say.

13. The National Rural Health Mission (NRHM), issued guidelines for effective implementation of the scheme "*Janani-Shishu Suraksha Karyakram (JSSK)"*. The relevant portions of the same are reproduced herein below;

> *"**Rationale:***
>
> *About 67,000 women in India die every year due to pregnancy related complications. Similarly, every year approximately 13 lakhs infants die within one year of birth. Out of 9 lakh newborns who die within four weeks of birth (2/3rd of the infant deaths) about 7 lakh i.e.75 per cent die within the first week (a majority of these in the first two days after birth). The first 28 days of infancy period are therefore very important and critical to save children. Both maternal and infant deaths could be reduced by ensuring timely access to quality services, both essential & emergency, in public health facilities without any burden of out of pocket expenses.*
>
> *While India has made considerable progress towards the reduction of Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR), the current pace of decline is not sufficient to achieve the goals and targets, committed under NRHM and MDG.*
>
> *With the lunch of Janani Suraksha Yojana (JSY), the number of institutional deliveries has increased significantly. There are however more than 25% pregnant women who still hesitate to access health*

facilities. Those who have opted for institutional delivery are not willing to stay for 48 hours, hampering the provision of essential services both to the mother and neonate, which are critical for identification and management of complications during the first 48 hrs after delivery. Important factors affecting access include:

- *High out of pocket expenses on-*
- *User charge for OPD, admissions, diagnostic tests, blood etc.*
- *Purchasing medicines and other consumables from the market*
- *In the case of a caesarean operation, expenses can be very high*
- *Non availability of diet in most institutions.*
- *Transport required to take pregnant women from home to the facility, to higher facility in case she is referred further, and for going back from the health institution to her home (which becomes a factor for going back home just after delivery by using the same transport.)*

The new Initiative- Janani-Shishu Suraksha Karyakram

Janani-Shishu Suraksha Karyakram (JSSK) launched from Mewat district in Haryana on June 1, unmistakably signals a huge leap forward in the quest to make "Health for All" a reality.

It invokes a new approach to healthcare, placing the first time, utmost emphasis on entitlements and elimination of out-of-pocket expenses for both pregnant women and sich neonates. The initiatives entitles all pregnant women delivering in public health institutions to absolutely free and no-expense delivery, including caesarean section.

It stipulates out that all expenses related to delivery in a public institution would be borne entirely by the Government and no user charges would be levied. Under this initiative, a pregnant woman would be entitled to free transport from home to Government health facility, between facilities, in case she is referred on account of complications, and also drop-back home after 48 hours of delivery.

Entitlements would include free drugs and consumables, free diagnostics, free blood wherever required, and free diet for the duration of a woman's stay in the facility, expected to be three days in case of a normal delivery and seven in case of a caesarean section.

Similar entitlements have been put in place for all sick newborns accessing public health institutions for healthcare till 30 days after birth. They would also be entitled to free treatment besides free transport, both ways and between facilities in case of a referral.

The initiative is estimated to benefit more than 1 crore pregnant women & newborn that access public health institutions every year in both urban & rural areas and also increase access to health care for the over 70 lakh women delivering at home. This initiative supplements the

cash assistance given to a pregnant woman under JSY and is aimed at mitigating the burden of out of pocket expenses incurred by pregnant woman and sick newborns.

Entitlement for Pregnant Women:

- *Free and zero expenses Delivery and Caesarean Section*
- *Free drugs and consumables*
- *Free essential diagnostics (Blood, Urine tests and Ultra-sonography etc)*
- *Free diet during stay in the health institutions (up to 3 days for normal delivery & 7 days for caesarean section)*
- *Free provision of blood*
- *Free transport from home to health institutions*
- *Free transport between facilities in case of referral*
- *Drop back from institutions to home after 48 hrs stay*
- *Exemption from all kinds of User charges*

Implementation of the New Initiative:

1. Actions at State level:
    - *Issue Government orders on free entitlements*
    - *Nominate a State Nodal Officer*
    - *Institute a grievance redressal mechanism for ensuring that the commitments are fulfilled in letter and spirit*
    - *Ensure regular procurement and availability of drugs and consumables at the public health institutions*
    - *Establish and operationalise blood banks at district levels and Blood Storage Centres at identified FRUs.*
    - *Establish district wise assured referral linkages with GPS fitted vehicles and centralised control rooms*
    - *Provide required finances and necessary administrative steps/G.O.s for the above activities*
    - *Financially empower the district and facility in-charges for the above activities, particularly in emergency situations/stock outs.*
    - *Regularly monitor and report on designated formats at specified periodicity*
    - *Review the implementation status during district CMOs meetings.*

II. Actions at District Level:

- *Nominate a District Nodal Officer*
- *Circulate the G.O on free entitlements to all facility in-charges.*
- *Widely publicise free entitlements in public domain*
- *Institute a grievance redressal mechanism for ensuring that the commitments are fulfilled in letter and spirit.*

- *Regularly review the stocks of drugs & consumables for ensuring availability at the public health institutions.*
- *Ensure lab facilities and diagnostics services are functional at all designated facilities, particularly at DH, SDH, FRU, CHC and 24x7 PHCs.*
- *Prepare time bound action plans for establishing and operationalising Blood Bank and District level and Blood Storage Centres at identified FRUs.*
- *Review referral linkages and their utilisation by beneficiaries.*
- *Provide required finances/empowerment for utilisation of funds to the Block MOs and facility in-charges for the above activities, particularly in emergency situations/stock outs.*
- *Regularly monitor & report on designated formats at specified periodicity.*
- *Review the implementation status during Block MOs/MOs meetings.*

III. Dessemination of the Entitlements in the public Domain:

- *Widely publicise these entitlements through print and electronic media*
- *Display them prominently on adequate size hoardings & Boards, which is clearly visible from distance in all Government health facilities e.g. SCs, PHCs, CHCs, SDHs and DHs/FRUs (main entrance, labour rooms, female and neonatal wards and outside outpatient areas) as per the enclosed format at Annexure-1*
    - *IEC budget sanctioned in the project Implementation Plan (PIP) under RCH/NRHM can be utilised for this.*

IV. Ensure Drugs and Consumables:

- *Notify the essential drug list for RCH services to be notified at all the service delivery points.*
- *Ensure regular procurement, uninterrupted supply and availability of drugs and consumables at all public health institutions.*
- *The daily availability of the drugs should be displayed at the health facility.*
- *Empower the head of the District/health facility to procure drugs & consumables to prevent stock outs.*
- *Ensure the quality and shelf life of drugs supplied.*
- *Ensure a proper inventory of drugs and consumables at each health facility for timely reporting on stock outs and expiry.*
- *In charge pharmacist of the facility to ensure availability of drugs at dispensing points i.e.labour room, OT, indoors, casualty, etc after the routine hours.*
- *Ensure that first expiry drugs and consumables are used first. "FIRST in & FIRST out" protocol.*

- *Ensure proper storage of drugs and consumables by keeping drug stores clean & tidy with adequate ventilation and cooling.*

V. Strengthen Diagnostics:

** Ensure lab and diagnostic service at DH, SDH, FRU, CHC & 24x7 PHCs*

** Ensure availability of basic routine investigations like pregnancy test, Hb & routine urine at sub-centre level, particularly those designated as delivery points.*

** Ensure rational posting of Lab technicians for integrated & Comprehensive utilization in all the programme.*

** Make emergency investigations available round the clock, at least at DH, SDH and FRU level.*

** Ensure uninterrupted supply of reagents, consumables and other essentials required for lab investigations.*

** Empower the head of the District/health facility to procure reagents, consumables and other essentials to prevent their shortage/stock out.*

** In case in-house lab & diagnostic services are not available, free investigations can be provided through PPP/outsourcing.*

VI Ensure Provision of Diet:

- *Ensure provision of diet (cooked food) at all delivery points from District Hospital up to 24x7 PHC*
- *If proper kitchen and adequate manpower is not available, then this service can be outsourced.*
- *Local seasonal foods, vegetables, fruits, milk and eggs can be given to her for a proper nutritious diet*
- *MO in-charge should monitor the quality of food being served at the health facility*
- *Diet is to be provided uo to three days for normal delivery and up to seven days stay for caesarean section (C-Section).*
- *The health facility should receive the funds in advance for ensuring provision of free diet for the pregnant women and delivered mother.*

VII Ensure Availability of Blood in case of need:

- *Prepare time bound action plans for establishing and operationalising Blood Bank at District level and Blood Storage Centres at identified FRUs.*
- *Maintain adequate stocks for each blood group.*

- *Ensure availability of reagents and consumables for blood before storage, and organise periodic voluntary blood donation camps for maintaining adequate number of blood units.*
- *Provide adequate funds to blood banks for electric backup and POL, and alternate source of power backup for blood bag refrigerators for blood storage units.*
- *MO in-charge/lab technician of the blood bank to periodically visit blood storage units for monitoring and supervision.*

VIII Exemption from all kinds of User Charges:

- *Issue Government Order for exemption from any user charge for pregnant women and sick newborns upto 30 days, at public health facilities.*

IX Referral Transport

Ensure universal reach of the referral transport (no area left uncovered), with 24x7 referral services.

- ** State is free to use any suitable model of transportation e.g. Government Ambulances. EMRI, referral transport PPP model etc.*
- ** Establish call centre(s) with a single toll free number, at District or State level.*
- ** May provide ambulances/vehicles with GPS, for effective tracking and management.*
- ** Establish linkages for the inaccessible areas (hilly terrain, flooded or tribal areas etc) to the road head/pick up points.*
- ** Widely publicise the free & assured referral transport through print and electronic media.*

** Monitor and supervise services at all levels, including utilisation of the each vehicle and number of cases transported.*

X Grievance Redressal

- *Prominently display the names, addresses, emails, telephones, mobiles and fax numbers of grievance redressal authorities at health facility level, district level and State level, and disseminate them widely in the public domain.*
- *Set up help desks and suggestion/complaint boxes at government health facilities.*
- *Keep fixed hours (at least 1 hour) on any two working days per week, in all the healthy facilities for meeting the complainants and redressing their grievances related entitlements.*
- *Take action on the grievances within a suitable timeframe, and communicate to the complainants.*
- *Maintain proper records of actions taken.*

XI. Funds

- *Reflect the requirement of funds in the State PIP under NRHM in addition to resources available from State budget.*

XII Monitoring and follow up:

- *At National Level, the scheme will be monitored by National Health Systems Resource Centre (NHSRC) under guidance and support from Maternal Health Division, Ministry of Health & Family Welfare, Government of India.*
- *At State and District level, the State Nodal Officer and District Nodal Officers will monitor and follow up the progress in implementation of the scheme. In CMOs meeting at State level, the Mission Director and during MOs meeting at district level, CMO will review the progress of the scheme.*
- *Monitoring checklist for National, State and District level is at Annexure III.*

Janani-Shishu Suraksha Karyakram (JSSK)

Assures NIL out of pocket expenses in all Government Health Institutions.

For Pregnant Women & Newborns

Entitlements for Pregnant Women:

- *Free delivery*
- *Free Caesarean section*
- *Free drugs and consumables*
- *Free diagnostics (Blood, Urine tests and Ultrasonography etc)*
- *Free diet during stay (upto 3 days for normal delivery and 7 days for caesarean section)*
- *Free provision of blood*
- *Free transport from home to health institution, between health institutions in case of referral and drop back home.*
- *Exemption from all kinds of user charges*

Entitlements for Sick Newborn till 30 days after birth:

- *Free and zero expense treatment*
- *Free drugs & consumables*
- *Free diagnostics*
- *Free provision of blood*
- *Free transport from home to health institution, between health institutions in case of referral and drop back home.*
- *Exemption from all kinds of user charges.*

14. Indian Public Health Standards (IPHS) Guidelines for Sub-centres Revised 2012 provided the guidelines for Sub-centres as follows;

"**Indian Public Health Standards (IPHS)**
Guidelines for Sub-Centres Revised 2012.

Categorization of Sub-Centres

In view of the current highly variable situation of Sub-centres in different parts of the country and even with in the same State, they have been categorized into two types- Type A and Type-B. Categorization has taken into consideration various factors namely catchment area, health seeking behaviour, case load, location of other facilities like PHC/CHC/FRU/Hospitals in the vicinity of the Sub-Centre. States shall be required to categorize their Sub-Centres into two types as per the guidelines given below and provide services and infrastructure accordingly. This shall result in optimum use of available resources.

.....

Type B (MCH Sub-Centre)

This would include following types of Sub-centres:

i. Centrally or better located Sub-centres with good connectivity to catchment areas.
ii. They have good physical infrastructure preferably with own buildings, adequate space, residential accommodation and labour room facilities.
iii. They already have good case load of deliveries from the catchment areas.
iv. There are no nearby higher level delivery facilities.

Guidelines

Such Sub-centres should be developed as a delivery facility and should also cater to adjacent Type A sub-centres areas for delivery purpose. Type B Sub-centre, will provide all recommended services including facilities for conducting deliveries at the Sub-centre itself. They will be expected to conduct around 20 deliveries in a month. They should be provided with all labour room facilities and equipment including Newborn care corner. ANMs of these Sub-centres should be SBA trained. These centres may be provided extra equipment, drugs, supplies, materials, 2 beds and budget for smooth functioning. If number of deliveries is 20 or more in a month, then additional 2 beds will be provided.

Staff recommended

Two ANM (Essential)
One Health Worker (Male): (Essential)

One Staff Nurse or ANM (if Staff Nurse not available)
(Desirable, if number of deliveries at the Sub-centre is 20 or more in a month)

Sanitation services should be provided through outsourcing on full time basis.

Services to be provided in a Sub-Centre.

Sub-Centres are expected to provide promotive, preventive and few curative primary health care services. Keeping in view the changing epidemiological situation in the country, both types of Sub-centres should lay emphasis on Non-Communicable Diseases related service.

Given the understanding of the health Sub-centre as mainly providing outreach facilities, where most services are not delivered in the Sub-centre building itself, the site of service delivery may be at following places:

a. *In the village: Village Health and Nutrition Day/Immunization session*
b. *During house visits*
c. *During house to house surveys.*
d. *During meetings and events with the community.*
e. *At the facility premises. It is desirable, that the Sub-centre should provide minimum of six of hours of routine OPD services in a day for six days in a week. Wherever two ANMs are provided, it shall be ensured that one of the ANMs is available at the Sub-centre and the Sub-centre remains open for providing OPD services on all working days. Only one of them may provide outreach services at a time.*

The main differences in services to be provided by the two types of Sub-centres are:

Type A: Shall provide all services as envisaged for the Sub-centre except the facilities for conducting delivery will not be available here.

Type B: They will provide all recommended services including facilities for conducting deliveries at the Sub-centre itself. This Sub-centre will act as Maternal and Child Health (MHC) centre with basic facilities for conducting deliveries and Newborn care at the Sub-centre.

Although the main focus shall be to promote institutional deliveries, however, the facilities for attending to home deliveries shall remain available at both types of Sub-centres. The following is the consolidated list of services to be provided through two types of Sub-centres. The services have been classified as Essential (minimum Assured Services) or Desirable (that all States/UTs should aspire to achieve).

Maternal and Child Health

Maternal Health

i. Antenatal care:

Essential

- *Early registration of all pregnancies, within first trimester (before 12th week of Pregnancy) However even if a woman comes late in her pregnancy for registration, she should be registered and care given to her according to gestationai age.*
- *Minimum 4 ANC including Registration Suggested schedule for antenatal visits.*

1st visit: Within 12 weeks-preferably as soon as pregnancy is suspected-for registration, history and first antenatal check-up
2nd visit-Between 14 and 26 weeks.
3rd Between 28 and 24 weeks
4th visit: Between 36 weeks and term

- *Associated services like general examination such as height, weight, B.P., anaemia, abdominal examination, breast examination, Folic Acid Supplementation from 12 weeks, injection tetanus toxoid, treatment of anaemia etc, (as per the Guidelines for Antenatal care and Skilled Attendance at Birth by ANMs and LHVs).*
- *Recording tobacco use by all antenatal mothers.*
- *Minimum laboratory investigations like Urine Test for pregnancy confirmation, haemoglobin estimation, urine for albumin and sugar and linkages with PHC for other required tests.*
- *Name based tracking of all pregnant women for assured service delivery.*
- *Identification of high risk pregnancy cases.*
- *Identification and management of danger signs during pregnancy.*
- *Malaria prophylaxis in malaria endemic zones for pregnant women as per the guidelines of NVBDCP.*
- *Appropriate and Timely referral of such identified cases which are beyond her capacity of management.*
- *Counselling on diet, rest, tobacco cessation if the antennal mother is a smoker or tobacco user, information about dangers of exposure to second hand smoke and minor problems during pregnancy, advice on institutional deliveries, pre-birth preparedness and complication readiness, danger signs, clean and safe delivery at home if called for, postnatal care & hygiene, nutrition, care of newborn, registration of birth, initiation of breast feeding, exclusive breast feeding for 6 months, demand feeding, supplementary feeding (weaning and starting semi solid and solid food) from 6 months onwards, infant & young child feeding and contraception.*
- *Provide information about provisions under current schemes and programmes like Janani Suraksha Yojana.*
- *Identify suspected RTI/STI case, provide counselling, basic management and referral services.*
- *Counselling & referral for HIV/AIDS.*

- *Name based tracking of missed and left out ANC cases.*

Intra-natal care

Essential

- *Promotion of Institutional deliveries*
- *Skilled attendance at home deliveries when called for*
- *Appropriate and Timely referral of high risk cases which are beyond her capacity of management*.

Essential for Type B Sub-centre

- *Managing using partograph.*
- *Identification and management of danger signs during labor.*
- *Proficient in identification and basic fist aid treatment for PPH, Eclampsia, Sepsis and prompt referral of such cases as per Antenatal Care and Skilled Birth Attendance at Birth or SBA Guidelines.*
- *Minimum 24 hours of stay of mother and baby after delivery at Sub-centre. The environment at the Sub-centre should be clean and safe for both mother and baby.*

Postnatal Care

Essential

- *Initiation of early breast-feeding within one hour of birth.*
- *Ensure post-natal home visit on 0,3,7 and 42nd day for deliveries at home and Sub-centre (both for mother & baby).*
- *Ensure 3, 7 and 42nd day visit for institutional delivery (both for mother & baby) cases.*
- *In case of Low Birth weight Baby (less than 2500 gm), additional visits are to be made on 14, 21 and 28th days.*
- *During post-natal visit, advice regarding care of the mother and care and feeding of the newborn and examination of the newborn for signs of sickness and congenital abnormalities as per IMNCI Guidelines and appropriate referral, if needed.*
- *Counselling on diet & rest, hygiene, contraception, essential newborn care, Immunization, Infant and young child feeding, STI/RTI and HIV/AIDS.*
- *Name based tracking of missed and left out PNC cases*.

Child Health.

Essential

- *Newborn Care Corner in the Labour Room to provide Essential Newborn Care (Annexure 5A): Essentials if Deliveries take place at the Sub-centre (Type B)*

- *Essential Newborn Care (maintain the body temperature and prevent hypothermia [provision of warmth/Kangaroo Mother Care (KMC], maintain the airway and breathing, initiate breastfeeding within one hour, infection, protection, cord care, and care of the eyes, as per the guidelines for Ante-natal Care and Skilled Attendance at Birth by ANMs and LHVs.*
- *Post natal visits as mentioned under 'Post natal care'.*
- *Counselling on exclusive breast-feeding for 6 months and appropriate and adequate complementary feeding from 6 months of age while continuing breastfeeding. (As per National Guidelines on Infant and Young Child Feeding, 2006, by Ministry of WCD, Government of India).*
- *Assess the growth and development of the infants and under 5 children and make timely referral.*
- *Immunization Services: Full Immunization of all Infants and children against vaccine preventable diseases as per guidelines of Government of India.*

Janani Suraksha Yojana.

Entitlements for Pregnant Women

1. *Free and Zero expense delivery and Caesarian Section*
2. *Free Drugs and Consumables*
3. *Free Diagnostics (Blood, Urine tests and Ultrasonography etc. as required)*
4. *Free diet during stay in the health institutions (up to 3 days from normal deliveries and upto 7 days for caesarean deliveries)*
5. *Free provision of the Blood*
6. *Free transport from home to health institutions, between facilities in case of referrals and drop back from institutions to home.*
7. *Exemption from all kinds of user charges*

Entitlements for Sick newborn till 30 days after Birth

1. *Free and zero expense treatment*
2. *Free Drugs and Consumables*
3. *Free Diagnostics*
4. *Free provision of the Blood*
5. *Free transport from home to health institutions, between facilities in case of referrals and drop back from institutions to home.*
6. *Exemption from all kind of user charges.*

Manpower

In order to provide above mentioned services, different categories of Sub-centres should have the following personnel.

Type of Sub-centre	*Sub-centre A*	*Sub-centre B (MCH sub-centre)*

Staff	*Essential*	*Desirable*	*Essential*	*Desirable*
ANM/Health Worker (Female)	*1*	*+1*	*2*	
Health Worker (Male)	*1*		*1*	
Staff Nurse (or ANM, if Staff Nurse is not available				*1***
Safai-Karamchari	*1(Part-time)*		*1(Full time)*	

The assured services of a sub-centre would change considerably with the pattern of staff availability. Where there is only one ANM, Reproductive and Child Health services would have the first priority. Good Logistics support is essential for maximizing the work output of the Sub-centre.

Physical Infrastructure.

A Sub-centre should have its own building. If that is not possible immediately, the premises with adequate space should be rented in a central location with easy access to population. The States should also explore options of getting funds for space from other Health Programmes and other funding sources.

Location of the Centre

For all new upcoming Sub-centres, following may be ensured:

- *Sub-centre to be located within the village for providing easy access to the people and safety of the ANM.*
- *As far as possible no person has to travel more than 3 km to reach the Sub-centre.*
- *While finalizing the location of the Sub-centre, the concerned Panchayat should also be consulted.*

Building and Lay out.

- *Boundary wall/fencing: Boundary wall/fencing with Gate should be provided for safety and security.*
- *In the typical layout of the Sub-centre, the residential facility for ANM is included, however, it may happen that some of the existing Sub-centres may not have residential facilities for ANM. In that case, some house should be available on rent in the Sub-centre headquarter village for accommodating the ANM.*
- *Residential facility for Health Worker (Male), if need is felt, may be provided by expanding the Sub-centre building to the first floor. The entrance to the Sub-centre should be well lit and easy to locate. It should have provision for easy access for disabled and elderly. Provision of ramp with railing to be made for use of wheel chair/stretcher trolley, wherever feasible.*

- *The minimum covered area of a Sub-centre along with residential quarter for ANM will vary depending on land availability, type of Sub-centre and resources.*
- *Separate entrance for the Sub-centre and for the ANM quarter may be ensured.*

Type B Sub-centre should have, about 4 to 5 rooms with facilities of

- *Waiting Room*
- *One Labour Room with one labour table and Newborn corner*
- *One room with two to four beds (in case the no. of deliveries at the Sub-centre is 20 or more, four beds will be provided)*
- *One room for store*
- *One room for clinic/office*
- *One Toilet facility each in labour room ward room and in waiting area (Essential)*

Residential Accommodation: This should be made available to the Health workers with each one having 2 rooms, kitchen, bathroom and Water Closet (WC). Residential facility for one ANM is as follows which is contiguous with the main Sub-centre area.

- *Room-1 (3.3 m x 2.7 m)*
- *Room 2 (3.3.m x 2.7 m)*
- *Kitchen-1 (1.8 m x 2.5 m)*
- *W.C (1.2 m x 9.0 m)*
- *Bath Room (1.5 m x 1.2 m)*

Residential facility for a minimum of 2 staff and desirably for 3 staff should be provided at the Type B (MCH) Sub-centres.

A typical layout plan for Type A Sub-centre with ANM residence having area of 85 square metres and type B Sub-centre having an additional area of 65 square metres on first floor, with area/space specifications is given at Annexure 3.

Signage

- *The building should have a prominent board displaying the name of the Centre in the local language at the gate and on the building.*
- *Prominent display boards in local language providing information regarding the services available and the timings of the Sub-centre should be displayed at a prominent place.*
- *Visit schedule of "ANMs" should be displayed.*
- *Suggestion/complaint box for the patients/visitors and also information regarding the person responsible for redressal of complaints, be displayed.*

Disaster Prevention Measure against Earthquake, flood and fire

(Desirable for all new upcoming facilities)

- *Earthquake proof measure – Building structure and the internal structure of SC should be made disaster proof especially earthquake proof. Structural and non-structural elements should be built in to withstand quake as per geographical/state govt. guidelines. Non-structural features like fastening the shelves, equipment etc are as important as structural changes in the buildings.*
- *SC should not be located in low lying area to prevent flooding.*
- *Fire fighting equipment – fire extinguishers, sand buckets, etc should be available and maintained to be readily available when there is a problem.*
- *The health staff should be trained and well conversant with disaster prevention and management aspects.*

Environment Friendly features

The SC should be, as far as possible, environment friendly and energy efficient. Rain water harvesting solar energy use of energy-efficient bulbs/ equipment should be encouraged.

Furniture

Adequate furniture that is sturdy and easy to maintain should be provided to the Sub-centre. The list of furniture has been annexed (Annexure 4)

Equipment

The equipment provided to the Sub-centres should be adequate to provide all the assured services in the Sub-centres. This will include all the equipment necessary for conducting safe deliveries at Sub-centres (for Type B Sub-centre), home deliveries (for both Type A and Type B), immunization, contraceptive services like IUD insertion, etc. In addition, equipment for first aid and emergency care, water quality testing, blood smear collection should also be available. Maintanance of the equipment should be ensured either through preventive maintenance/prompt repair of non functional equipment so as to ensure uninterrupted delivery of services. A standard mechanism should be in place for the same. The list of equipment has been annexed (Annexure-5). Proper sterilization of all equipment and compliance of all Universal precautions are to be ensured.

Support Services

a. *Laboratory: Minimum facilities of Urine Pregnancy testing, estimation of Maemoglobin Colour Scale (only approved test strips should be used) urine test for the presence of protein and sugar by using*

Dipsticks should be available. (Instructions should be followed from the leaflet provided by the manufacturer)

b. *Electricity: Wherever facility exists, uninterrupted power supply has to be ensured for which inverter facility/solar power facility is to be provided. Generator facility is made available at Type B Sub-centres.*
c. *Water: Potable water for patients and staff and water for other use should be in adequate quantity. Towards this end, adequate water supply and water storage facility (over head tank) with pipe water should be made available especially where labour room is attached. Safe water may be provided by use of technology like filtration, chlorination, etc as per the suitability of the centre. Water source for Sub-centre be provided by the Panchayat and where there is need a tube well with fitted water pump be provided. For continuous water supply, States may explore, the option of rain water harvesting, solar energy for running the pumps etc.*
d. *Telephone: At Type B Sub-centres, landline telephone facility should be provided.*
e. *Assured Referral Linkages: Either, through Govt/PPP model for timely and assured referral to functional PHCs/FRUs in casae of complications during pregnancy and child birth.*
f. *Toilet: Toilet facility for use of patients/attendants and Sub-centre Staff must be provided in all Sub-centres. In case of Type B Sub-centre, additional one Toilet facility each in labour room and ward room are also to be provided. Regular cleaning of Toilets should be ensured.*

Waste Disposal

Infection Management and Environment Plan "Guidelines for Health Care Workers for Waste Management and Infection Control in Sub-centres" of Ministry of Health and Family Welfare, Government of India are to be followed. Standards and Deep Burial Pit as per Bio-Medical Waste (Management and Handling) Rules, 1988 are given at Annexure-7.

Record Maintenance and Reporting

Proper maintenance of records of services provided at the Sub-centres and the morbidity/mortality data is necessary for assessing the health situation in the Sub-centre area. In addition, all births and deaths under the jurisdiction of sub-centre should be documented and sex ratio at birth should be monitored and reported. A list of minimum number of registers to be maintained at Sub-centre is given in Annexure B.

Monitoring Mechanism

Internal mechanisms; Supportive supervision and Record checking at periodic intervals by the Male and Female Health supervisors from PHC (at least once a week) and by MO of the PHC (at least once in a month) etc. A check list for Sub-centres is given at Annexure 9.

External mechanisms: Sub-centres will be under the oversight of Gram Panchayats. A simpler check-list that can be used by PRI/NGO/SHG is given in Annexure 9 A.

A detailed Facility Survey Format (Annexure 10) is also given to monitor periodically whether the Sub-centre is up-to the level of Indian Public Health Standards (IPHS)

PRI should be involved in the monitoring. The following may be monitored:

- *Access to service (equity). Location of Sub-centres ensuring it to be safe to female staff and centrally located, well inside the inhabited area of the village.*
- *Registration and Referral Procedures: promptness in attending to clients; transportation of emergency maternity cases etc.*
- *Management of untied fund for the improvement of services of the Sub-centre*
- *Staff behaviour*
- *Other facilities: waiting space, toilets, drinking water in Sub-centre building.*

Quality Assurance and Accountability.

This can be ensured through regular skill development training/Continuing Medical Education (CME) of health workers (at least one such training in a year), as per guidelines of NRHM.

In order to ensure quality of services and patient satisfaction, it is essential to encourage community participation. To ensure accountability, the Citizens Charter should be available in all Sub-centres (Annexure 11).

15. Human Rights Law Network a voluntary organization published a write up regarding these findings on the death of (L) Bema mother of the petitioner whose death is the subject matter in this writ petition. The same is also reproduced here below;

"***Maternal and Infant Death Case. Monyakshu Village, Mon District, Nagaland.***
Human Rights Law Network.
Fact-Finding Survey

Social activists from the Human Right Law Network conducted a fact-finding survey in Monyakshyu village under Mon District of Nagaland on 14th July 2016. They met with the family of Lt. Mrs. Bema aged 30 years old, who passed away during the birth of her 7th child, a stillborn.

Profile of Bema

Bema lived with her husband, Mr. Shahyan aged 50 years and her four children, two boys and two girls, aged between 2 years to 25 years. The eldest son, Moba, aged 25, is her step son, from her earlier marriage of her husband. In all, Bema gave birth to six children, all of which were delivered at her home assisted by her husband. Three out of six succumbed to bouts of jaundice and measles. All three had been older than a year but less than 5 years of age. None of the children have ever been immunized, including the eldest son. Bema was illiterate as is her husband. None of the children have received any schooling due to poor social economic status and their inability to afford it. The family resides in remote village of Monyakshyu, which is the biggest village under Mon District. The nearest health centre is the Monyakshyu Sub-Centre which is only few metres from the residence of the deceased. The Primary Health Centre, Changlangshu is about 4 kms away. The District Hospital Mon is 130 km away from the village. Given the deplorable road condition the journey to and from the village to the district hospital can span anywhere between 8 to 9 hours. Public transport of bus and sumo services are very limited. During emergencies private vehicles have to be relied on and finding one is a gargantuan task in itself.

FACTS

The recent pregnancy which took away Bema's life was her sixth pregnancy. In all of her earlier pregnancies, she could never avail any of the scheme under the NHM as she was oblivious of it with the Sub-Centre perpetually remain closed. On 11th July 2016, Bema gravid 7 para 6 tried to deliver her baby at home with the help of her husband. Her labor pain started from 2.00 am which lasted for 4 hours. After a period of strenuous pushing and agony, one arm of the baby emerged from her birth canal. By then Bema was exhausted and couldn't proceed to pushing further. It was then decided that they would take her to Mon District Hospital, 130 km away from the village. This was hundred by the lack of transportation, as even on any other day, let alone during emergency such as this, it would take about one or two hours to find any form of public transportation. The family also did not have any means of calling for an ambulance. Finally, at 6.00 am, after much struggle and difficulties they got a private vehicle at the cost of Rs.16000 and hired it to take them to the hospital. On the way to hospital at around 6.30. am Bema passed away with the baby still inside her womb. The baby which was half way out from her womb could not exit the pelvis bone, failing to see the light of the day. Her body was brought back to her home along with her infant baby. Bema and her baby were buried together on the same day. It was an obstructed labor case and regrettably critical time was wasted in finding a vehicle, an eventuality which became

unavoidable owing to the non-availability of emergency services in both the sub-centre and nearby Primary Health Centre. Obstructed labor is one of the most common causes of preventable maternal mortality, wherein, though the uterus may be contracting normally, yet the baby is unable to exit the pelvis due to physical blockage. Bema's death has been a huge loss for the family and particular for her youngest, a 2 year old daughter, who will now have to grow up with the tangible void left her mother's untimely death.

The Monyakshyu sub-centre which is situated nearby family's home is closed practically almost every day of the month. The staff at the sub-centre visits the centre only once a month with the sole purpose of immunization. The lack of full-time presence of personnel at the sub-centre is a glaring issue which acquires a graver tone as the staff members cite lack of shortage of medicines as the reason for their absence from their designated posts at the sub-centre.

The sub-centre also lacks any specialized care unit or facilities that the Government mandates a sub-centre must have. The closest Primary Health Centre is in Changlangshu village, 4 km away from the village, but the condition of the PHC is in mush too similar condition as the sub-centre.

The family lives in a kutcha house made of mud and bamboos, a traditional house structure with one big kitchen and one or two additional rooms. The family eat and sleep together in the kitchen-cum-room. A toilet is attached near the kitchen but is a makeshift one. The family still practices the old way of feeding their domesticated animal (pigs) with their excreta which has left the premises of their home far from being sanitary or hygienic. Bema and her husband both worked from morning till evening in their own agricultural land measuring approximately 3 bigha (120/120 sq ft x 3), and the produce from this plot served as the only source of sustenance for the entire year. With no source of income, they would sell their produce, like rice, to earn a little money when required."

16. From the guidelines of the National Rural Health Mission (NRHM) given for Janani-Shishu Suraksha Karyakram (in short, JSSK) one can see that what a pregnant women requires before and during the delivery and thereafter are to be provided free of cost not only to reduce mortality of women and infants during such periods but also to ensure good health to mothers and infants. There is no need of re-stating all the benefits under the scheme and the mechanism through which the scheme are to be implemented since they have been stated above already. Suffice to state that the major portion of the fund is provided by the Central Government and the States are also to make some

contribution but to be more responsible in the implementation of the scheme both through their existing infrastructures and enhanced infrastructures with funds provided by the Centre. Among the infrastructures for successful implementation of the scheme is Primary Health Sub-centre Type-B. As given in the revised guidelines for Sub-Centres, 2012 this category of Sub-centre among others should have labour room facility and they should be adequately equipped to be able to conduct 20 deliveries in a month and they are to be manned by at least 2 ANMs of SAB trained, 1 health worker, 1 staff nurse or ANM (staff nurse or ANM, if staff not available) and 1 Safai-Karamchari. On and above the manpower stated above assistance or service of trained health worker called, ASHA is also to be made available to the Sub-centre. The role of ASHA is to act as an effective link between field level health provider and the poor pregnant women. The Sub-centre at the village of the petitioner is stated to of Type-B. Therefore, it is expected to have all the infrastructures and facilities stated above.

17. In remote areas like petitioner's village, where people are not so educated, still backward, poverty stricken and are still control by their traditional beliefs to great extend, such Sub-centres are expected to be more proactive so that awareness is well spread and women are encouraged to come forward for regular check-up during pregnancy and also to come forward for institutional deliveries to ensure their own safety and that of their unborn and newborn children and, in case of complicated cases they are assisted to go to better equipped hospitals with transportations provided free of cost and all the assistance that are required during delivery and after delivery. This kind of schemes looks noble and indeed they are, but they are the outcome of the efforts of the Central Government in discharging its duties and obligations under Article 21 of the Constitution. Therefore, everyone who is responsible to ensure implementation of such scheme should discharge their respective duties with a sense of responsibility and accountability. However, it is unfortunate that such sense appears to be still wanting among the stake holders in the State.

18. It has been submitted by Mr. N. Mozhui that the Sub-centre in the village of the petitioner was opened all the time and all the staffs were also present specially during that period of time when the unfortunate incident happened but the petitioner's mother never visited the Sub-centre nor was she

ever brought for check-up or delivery, therefore, the respondents cannot be held responsible for the death of the petitioner's mother. I am unable to accept the submission of the learned counsel for two reasons; (i) because it is the duty of the people posted at the Sub-centre including the ASHA to spread awareness and to convince such woman to visit the Sub-centre and to avail such benefits or facilities provided under the scheme, (ii) because it is not plausible that people in such circumstances would have hired a vehicle to go to a hospital situated at the place more than 120 Kms away from their village while such facility is easily available at their own village. Moreover, from the independent enquiry conducted by the Human Rights Law Network which is an independent body and not expected to be bias against anybody it has been revealed that the Sub-centre was found to be in dilapidated condition and also not open on the day the unfortunate incident took place. The relevant portions of the report have been already extracted in this judgment.

19. Perusal of the guidelines of the NRHM shows that at every level mechanism for monitoring the implementation of the scheme are envisaged however, it appears that such mechanisms have been created only for namesake. If they have been alive and doing their duties the Sub-centre of the village would have been active and vibrant and such unfortunate incident would have been prevented. In fact, such incident does not seem to have shocked the conscience of the people at every level responsible. If they were, one would have seen some action taken to make some people accountable so that at least such incident does not occur again in the future.

20. Article 21 of the Constitution reads as follows;

> **"*Protection of life and personal liberty*-** *No person shall be deprived of his life or personal liberty except according to procedure established by law."*

This Article ensures every person right to life and personal liberty. Expression of life in this Article has been interpreted by the Supreme Court liberally and broadly. Over time, the Court has given expansive interpretation to the word 'life'. In the case of **Francis Coralie** –versus- **Delhi**, reported in **AIR 1981 SC 746**, Justice Bhagwati had observed as follows;

> *"We think that right to life includes the right to live with human dignity and all that goes along with it namely, the bare necessaries of life such as adequate nutrition, clothing and shelter over the head and facilities for reading, writing and expressing oneself in diverse forms, freely moving about and mixing and commingling with fellow human beings."*

It was also further held in the same case that expression of *'life'* in Article 21 does not connote merely physical or animal existence but embraces something more. This observation of the Hon'ble Supreme Court shows that the ambit and sweep of the *"right to life"* embodied in Article 21 is wide and far reaching.

In the case of **Vincent Panikulangara** –versus- **Union of India**. The Hon'ble Supreme Court of India observed as follows;

> *"Maintenance and improvement of public health have to rank high as these are indispensable to the very physical existence of the community and on the betterment of these depends the building of the society of which the Constitution makers envisaged. Attending to public health in our opinion, therefore, is of high priority perhaps the one at the top."*

Further in **State of Punjab and Others** –versus- **Mohinder Singh Chawala**, it has been held that right to health is integral to right to life and government has a constitutional obligation to provide health facilities.

The issue of adequacy of medical health services was also addressed in **Paschim Banga Khet Mazdoor Samity** –versus- **State of West Bengal**. The question before the Court was whether the non-availability of services in the Government health centres amount to a violation of Article 21? It was held that Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government hospitals run by the State and the medical officers employed therein are duty-bound to extend medical assistance for preserving human life. And, failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21. Therefore, the failure of a Government run health centre to provide timely treatment is violative of a person's right to life. Further, the Court ordered that Primary health care centres be equipped to deal

with medical emergencies. It has also been held in this judgment that the lack of financial resources cannot be a reason for the State to shy away from its constitutional obligation.

In **Mahender Pratap Singh** –versus- **State of Orissa**, a case pertaining to the failure of the government in opening a primary health care centre in a village, the court had held "In a country like ours, it may not be possible to have sophisticated hospitals but definitely villagers within their limitations can aspire to have a Primary Health Centre. The government is required to assist people get treatment and lead a healthy life. Healthy society is a collective gain and no Government should make any effort to smother it.

Primary concern should be the primary health centre and technical fetters cannot be introduced as subterfuges to cause hindrances in the establishment of health centre." It also stated that, "great achievements and accomplishments in life are possible if one is permitted to lead an acceptably healthy life".

The implication from the above is that the enforcing of the right to life is a duty of the state and that this duty covers the providing of right to primary health care. This would then imply that the right to life includes the right to primary health care.

21. The right to healthy life is inherent in Article 21, therefore, health and medical care comes within the sweep of Article 21. Right to healthy life refers to and mean the most attainable levels of health that every human being is entitled to. Health has been much regarded as the basic and fundamental human right by the International community under international human rights law. In contrast to all the other human rights, the right to health creates an obligation upon the State to ensure that the right to health is respected, protected and fulfilled, and is duly entitled to all its citizens.

Further in the case of **P. Parmananda Katara** –versus- **Union of India & Others**, the Hon'ble Supreme Court has specifically stated that preservation of life is of paramount importance. Once life is lost, status quo ante cannot be restored. Article 21 casts the obligation on the State to preserve life. Therefore, those who are in-charge of the health of the community are

under obligation and are duty-bound to ensure that the basic facilities which are intended to be made available for the poor and needy and in this case-women and child reaches the targeted persons. However, in this case the failure on the part of the respondents in the discharge of their duties in making the basic facilities and benefits provided under NRHM scheme or schemes reach the poorest of the poor in the villages of Nagaland particularly, the village of the petitioner is quite evident from the facts and circumstances submitted by the petitioner through his learned counsel and from the finding of the Human Rights Law Network. But for their failure in the discharge of their duties the precious life of the petitioner's mother and the unborn child could have been save. Life is precious and once it is gone it cannot be brought back, it is irreparable loss.

22. The two grounds of preliminary objection raised by Mr. N. Mozhui which are given at para-6 of this judgment do not have much force under the facts and circumstances of the case. Firstly, because making of a request or demand before a writ petition under public law is filed is to give a chance to the authority to consider the grievance of the petitioner. Therefore, none submission of a representation or a demand prior to filing of a writ petition is not an absolute prerequisite for approaching a writ court under public law. Secondly, all the responsible persons who are stakeholders have been impleaded in the writ petition, therefore, non impleadment in the Village Health Management Committee, ANM and ASHA posted at Sub-centre concerned does not make the writ petition improper or defective in anyway.

23. In view of the above discussions and conclusions, I am of the view that the only relief that can be given under public law in the facts and circumstances of the case is awarding some amount of money as exemplary compensation and the cost of litigation. Therefore, considering the socio economic condition of the family of the deceased, the facts and circumstances of the case, it is considered just and proper to direct the respondents to pay a sum of Rs. 25 lakh as exemplary compensation and also to pay a sum of Rs. 15,000/- to meet the legal expanses. The respondents are directed accordingly.

Further, since the deceased was entitled to free transportation charge for going to hospital the respondents should also reimburse the amount spent.

Lastly, the claim of the petitioner under NFBS is not opposed by the learned Government Advocate. The only thing submitted by her is that the District Welfare Officer has not been made a party and no enquiry has been conducted for the purpose. The first ground of objection is not exceptable as the Commissioner and the Director of the Social Welfare are already impleaded and the second ground of objection also is not exceptable because under the scheme a woman who is a homemaker is covered. In this case, the deceased was the mother of the petitioner and other six children, therefore, definitely a homemaker of the family and hence her family members are entitled to the benefits under the scheme. As such, the respondents are also directed to pay a sum of Rs. 20,000/- to the petitioner and his family under NFB Scheme as the same has not been paid to them.

The respondents should comply with the directions of this Court given above within a period of 3(three) months from the date of receipt of a copy of this order. Since there is an element of negligence on the part of those who are responsible for the implementation of the scheme, if the Government of Nagaland wishes, the amount of compensation may be recovered from those persons responsible.

JUDGE

Kevi

30-09-2019